CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Summary Plan Description (SPD)
and
Rules and Regulations for
Active Participants and Dependents

PLANS A, B, R AND FLAT RATE

Revised November 1, 2016

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Summary Plan Description (SPD)
and
Rules and Regulations for
Active Participants and Dependents

PLANS A, B, R AND FLAT RATE

Revised November 1, 2016

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

265 Hegenberger Road, Suite 100
Oakland, California 94621-1480
(510) 633-0333 • Toll-Free (888) 547-2054
www.carpenterfunds.com

EMPLOYER TRUSTEES

Don Dolly
Randy Jenco
Mike Mencarini
Larry Nibbi
Chuck Palley
Joseph R. Santucci
Roy Van Pelt

LABOR TRUSTEES

Robert Alvarado
Augie Beltran
Frank Crim
William Feyling
Curtis Kelly
Timothy Lipscomb
Tom Mattis

LEGAL COUNSEL

Kraw Law Group
and
Weinberg, Roger & Rosenfeld

CONSULTANT

The Segal Company

AUDITOR

Hemming Morse, LLP

ADMINISTRATIVE OFFICE

Carpenter Funds Administrative Office
of Northern California, Inc.
Gene H. Price, Administrator

TABLE OF CONTENTS

INTRODUCTION

What This Document Tells You

This Summary Plan Description (SPD)/Rules and Regulations is designed to help you understand the benefits available to you through the Carpenters Health and Welfare Trust Fund for California. The Trust Fund provides different levels of benefits based on your Employer contributions. The plans described in this SPD (Plan A, Plan B, Plan R and the Flat Rate Plan which are collectively referred to as the "Plan") are effective November 1, 2016 and replaces all other SPD/Rules and Regulations previously provided to you.

If uncertain, contact the Trust Fund Office for which plan you are enrolled in.

The Plans offer a wide range of benefits that are described in this Summary Plan Description (SPD)/Rules and Regulations, including:

- Indemnity Medical Plan;
- Mental Health and Chemical Dependency benefits;
- Member Assistance Program (MAP) benefits;
- Prescription Drug benefits;
- Dental benefits;
- Orthodontic benefits for dependent children;
- Life Insurance and Accidental Death & Dismemberment Insurance (Not applicable to Plan R Participants);
- Supplemental Weekly Disability Benefits (Not applicable to Flat Rate Plan Participants);
- Hearing Aid coverage; and
- Vision Care benefits.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information.

No individual shall have vested rights to benefits under these Plans. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Health Plan benefits are not vested and are not guaranteed.

If you have any questions about your coverage or your obligations under the terms of your Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

IMPORTANT INFORMATION

Carpenters Health and Welfare Trust Fund for California is committed to maintaining health care coverage for Participants and their families at an affordable cost, however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The Indemnity Medical Plan (including mental health and substance abuse treatment, a Member Assistance Program and prescription drugs), hearing aid benefits, dental, orthodontic, vision and Supplemental Weekly Disability benefits of the Plan are self-funded with contributions from the contributing employers and Eligible Participants held in a Trust. Life and Accidental Death and Dismemberment and the Kaiser HMO benefits of the Plan are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document.

About this SPD

In this SPD we have tried to describe your benefits as completely as possible and in everyday language. This SPD includes:

- An important **contact information** section, which includes telephone numbers and web sites for the Trust Fund Office and other organizations providing services under the Plan, including contact information for Utilization Review.
- An **eligibility** section that summarizes the eligibility requirements that you must satisfy to qualify for benefits.
- An explanation about your coverage under **each benefit program** of the Plan, including a ***Summary of Benefits*** for each benefit program that summarizes the coverage available.
- A section on **how to file claims** including what you need to do to file an appeal if a claim is denied.
- An **administrative information** section including general Plan information and your rights under the law.

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Ingles. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contactó con la Trust Fund Office a la dirección y teléfono en el Quick Reference Chart de este documento.

The life insurance and accidental death and dismemberment benefits are provided through a contract between the Board of Trustees and Voya Financial/ReliaStar Life Insurance Company.

The Indemnity Medical Plan (including mental health and substance abuse treatment, a Member Assistance Program, prescription drugs), weekly disability, vision, hearing aid, dental, and orthodontic benefits are not insured by any contract of insurance, and there is no liability on the part of the Board of Trustees or any individual or entity to provide payment over and beyond the amount in the Trust Fund collected and available for that purpose.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. No individual trustee, Employer or union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

The Board of Trustees has the right to change or discontinue both the types and amounts of benefits under this Plan and the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated. The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time a claim occurs.

Please Note

The Board has authorized the Trust Fund Office to respond in writing to your written questions. If you have a question about your benefits, contact the Trust Fund Office. As a courtesy to you, the Trust Fund Office may also respond informally to oral questions in good faith. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. If this occurs, you will receive a written notice explaining the change. Please be sure to read all Plan announcement letters about benefit changes and keep them with this booklet. In order for you to be aware of the benefits available to you and your Dependents, we urge you to read this booklet carefully prior to obtaining medical care. If you have any questions about your benefits described in this booklet, please contact the Trust Fund Office, where we will be pleased to assist you.

The Carpenters Health and Welfare Trust Fund for California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Indemnity Medical Plan's Utilization Review and Contract Provider programs continue to be critical elements of efforts to contain rising health care costs. There are financial incentives for you to use these cost containment programs.

Unfamiliar Term?

If you see a word whose meaning you are unsure of, check the Definitions section in Article I of the Rules and Regulations that follow the SPD. It contains definitions of the words used in the SPD.

However, because the following terms are so important, we are providing the definitions here so that you understand the meaning of these terms when you see them in the SPD. For the complete legal definition of these terms, please refer to Article I of the Rules and Regulations.

Allowed Charge: means the lesser of:

a. The dollar amount this Fund has determined it will allow for covered Medically Necessary services or supplies performed by Non-Contract Providers. The Fund's Allowed Charge amount is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), usual, customary and reasonable (UCR), prevailing or any similar term. A charge billed by a provider may exceed the Fund's Allowed Charge. The Fund reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the amount the Fund will allow for submitted claims. **When using Non-Contract Providers, the Eligible Individual is responsible for any difference between the actual billed charge and the Fund's maximum Allowed Charge, in addition to any copayment and percentage coinsurance required by the Plan.**

b. The Provider's actual billed charge.

c. The Fund has adopted a Medicare based reimbursement strategy for Non-Contract Hospital, Non-Contract Facility and other Non-Contract Providers where the maximum amount payable by this Plan is a percentage of the amount that would have been payable in accordance with Medicare allowable payments.

Experimental or Investigational: means a drug or device, medical treatment or procedure if:

(1) The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) The drug, device, medical treatment or procedure, or the Patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) **Reliable Evidence** shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) **Reliable Evidence** shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, **"Reliable Evidence"** means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Medically Necessary: means for the purpose of determining unreduced covered benefits payable by the Fund for services received for the treatment of an Illness or Injury. Services that are not Medically Necessary (except the routine preventive services specifically covered by the Plan) are not Allowed Charges.

Medically Necessary services or supplies are those determined to be:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
- Provided for the diagnosis or direct care and treatment of the medical condition, and
- Within standards of good medical practice within the organized medical community, and
- Not primarily for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Health Care Practitioner, or any Hospital or Specialized Health Care Facility. The fact that your Physician may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered Medically Necessary for the medical coverage provided by the Plan, and
- The most appropriate supply or level of service that can safely be provided. For Hospital stays, this means that acute care as a bed patient is needed due to the kind of services the patient is receiving or the severity of the patient's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting, as determined by the Professional Review Organization.

Prevailing Authority of Rules and Regulations

The provisions of the Plan are subject to and controlled by the legal Plan Document or Rules and Regulations. If there is a discrepancy between this Summary Plan Description (SPD) and the provisions of the Rules and Regulations, the provisions of the Rules and Regulations will govern. The Rules and Regulations are printed at the back of this SPD and are also available on the Fund's website (www.carpenterfunds.com).

Grandfathered Health Plan Under the Patient Protection And Affordable Care Act (The Affordable Care Act)

This group health plan believes that all of the Indemnity Medical Plans offered by the Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at (888) 547-2054 or (510) 633-0333.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

IMPORTANT CONTACT INFORMATION

The Plan is sponsored and administered by the Board of Trustees. However, the Trustees have delegated certain administrative responsibilities to other individuals or organizations as follows:

- **Trust Fund Office**:
  - Maintains eligibility records;
  - Accounts for Employer and self-payment contributions;
  - Administers Indemnity Medical, Hearing Aid, Supplemental Weekly Disability and Orthodontic claims;
  - Answers Participant inquiries; and
  - Handles other routine administrative functions.
- **Kaiser Foundation Health Plan** offers a Health Maintenance Organization (HMO) plan for medical and prescription drug benefits.
- **Indemnity Medical Plan**
  - **Anthem Blue Cross of California** provides access to a Contract Provider network for indemnity medical benefits and provides the Plan's utilization review program for certain medical benefits.
  - **Express Scripts** provides access to contract pharmacies and administers the Plan's mail service program and specialty pharmacy program (for Indemnity Medical Plan participants).
  - **Vision Service Plan (VSP)** administers and provides access to Contract Providers for Vision Benefits
- **Delta Dental of California** administers the Plan's dental benefits. (Orthodontic benefits are administered by the Trust Fund Office.)
- **Voya Financial/ReliaStar Life Insurance Company** insures and administers the Plan's Life Insurance and Accidental Death and Dismemberment Benefits. The group policy number is 62523-0GAT.

When you need information, please check this document first. If you need further help, call the individuals listed in the following Quick Reference Chart:

►When to Contact the Trust Fund Office	
When you have questions about: eligibility, benefits, COBRA continuation coverage, Employer and self-payment contributions, Disability Extension, Supplemental Weekly Disability, Member Assistance Program, Life Insurance, Accidental Death & Dismemberment Claims (AD&D), Orthodontic Benefits and other routine administrative functions.	Direct line: (510) 633-0333 Toll Free: (888) 547-2054 Email: benefitservices@carpenterfunds.com www.carpenterfunds.com
►Who to contact if you have questions about your Indemnity Medical Plan	
Claims and appeals for the Indemnity Medical Plan	**Trust Fund Office:** Direct line: (510) 633-0333 Toll Free: (888) 547-2054 Email: claimservices@carpenterfunds.com www.carpenterfunds.com
Indemnity Medical Plan benefits	
Hearing Aid Benefits	

►*Who to contact if you have questions about your Indemnity Medical Plan (continued)*	
Medicare Part D Notice of Creditable Coverage Summary of Benefits and Coverage (SBC) HIPAA Privacy Notice	**Trust Fund Office** Direct line: (510) 633-0333 Toll Free: (888) 547-2054 Email: benefitservices@carpenterfunds.com www.carpenterfunds.com
Finding a contract provider (for the Indemnity Medical Plan)	Inside California: **Anthem** (800) 810-2583 www.anthem.com Outside California: **Blue Card** (800) 810-2583 www.bcbs.com or
For assistance with non-emergency medical questions	**Anthem 24/7 Nurse Line** (800) 700-9184
Review Organization for Required Utilization Review – In or Outside California	**Anthem** (800) 274-7767 (Physicians Only)
Prescription Drugs - Network Pharmacy, Mail Service and Specialty Pharmacy Services (Kaiser HMO Participants, contact Kaiser for information about your prescription drug benefits)	**Express Scripts** (800) 939-7093 www.express-scripts.com (800) 473-3455 (to order refills) (800) 753-2851 (for doctors to request Utilization Review **Trust Fund Office:** (888) 547-2054
Vision Benefits	**Vision Service Plan (VSP)** (800) 877-7195 www.vsp.com

►*Who to contact if you have questions about your Kaiser HMO benefits*
Kaiser Member Services (800) 464-4000 www.kp.org

►*Who to contact if you have questions about your Member Assistance Program (MAP) for both the Indemnity Medical Plan and the Kaiser HMO*
Anthem MAP (800) 999-7222 www.anthemeap.com (Member Log in: Carpenters Trust)

►*Who to contact if you have questions about your COBRA Continuation Coverage*
Trust Fund Office Direct line: (510) 633-0333, Toll Free: (888) 547-2054 Email: benefitservices@carpenterfunds.com www.carpenterfunds.com

►*Who to contact if you have questions about your Dental Benefits*
Delta Dental (Delta Preferred Option) (800) 765-6003 www.deltadentalins.com

►*Who to contact if you have questions about Health Insurance Marketplace*
Residents of California: Covered California www.coveredca.com/ **Residents of Other States: Health Insurance Marketplace** www.healthcare.gov

ENROLLMENT AND ELIGIBILITY

Enrollment Procedure

Every Participant working for a Contributing Employer must complete an enrollment form. Blank enrollment forms are available on-line at www.carpenterfunds.com or at the Trust Fund Office. Proper enrollment is required for coverage under this Plan. If enrollment has been requested but proper enrollment (including submission of supporting documents) has not been completed, claims will not be able to be considered for payment until such enrollment has been completed and submitted to the Trust Fund Office.

If a Participant submits an incomplete enrollment form (i.e. does not elect Kaiser or the Indemnity Medical Plan), the entire family will be defaulted to the Indemnity Medical Plan until your enrollment is perfected.

Kaiser has a limited retroactive period that may limit your access to the Kaiser benefit option.

The enrollment form is also the means by which you designate your beneficiary for the life insurance and accidental death and dismemberment insurance benefits (if you are in Plan A, R or Flat Rate) and may be used to designate a beneficiary under other programs provided by the Carpenter Funds.

You must remain in any plan you have elected for at least 12 months (unless you are enrolled in Kaiser and you move out of the service area). You may then change to another plan by submitting a new enrollment form indicating the change to the Trust Fund Office. The change will go into effect the first day of the second calendar month following the date your enrollment form is received by the Fund.

Proof of Dependent Status

Specific documentation to substantiate Dependent status will be required by the Plan, and may include a birth certificate, marriage certificate, proof of the dependent's age, and the dependent's social security number. Below are other items the Plan may request to substantiate Dependent status. **Note that failure to provide timely proof of dependent status means that claims submitted to the Plan for the dependents will not be able to be considered for payment until such proof is provided.**

- **Marriage:** the certified marriage certificate.
- **Birth:** the certified birth certificate showing biological child of Participant.
- **Stepchild:** the certified birth certificate, divorce decree and marriage certificate.
- **Adoption or placement for adoption**: court order paper signed by the judge showing that the Participant has adopted or intends to adopt the child, birth certificate.
- **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate and proof that the child is considered your dependent for federal income tax purposes;
- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the Dependent child is currently mentally or physically disabled, provided the child was disabled and eligible as a Dependent under this Plan before reaching the limiting age.
- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice.
- **Domestic Partner**: The Participant and domestic partner affidavit and evidence of joint financial responsibility showing they meet the requirements of this Plan's domestic partner eligibility.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Option to Decline Dental Plan and/or Vision Plan Coverage

In accordance with Health Reform regulations, you have the option to decline the Plan's dental and vision coverage.

- Note that there is no additional compensation to you if you choose to decline/waive dental and/or vision coverage.
- If you would like to decline dental and/or vision coverage, please notify the Trust Fund Office in writing.

Changes to your enrollment in the dental plan and/or vision plan coverage is permitted once each 12-month period.

Plan Benefits

Depending on whether you and your covered Dependents are covered under **Plan A, Plan B, Plan R or the Flat Rate Plan**, you have a variety of benefits offered. The following chart outlines the available benefits for you and your covered Dependents under each plan option.

Type of Benefit	Plan A	Plan B	Plan R	Flat Rate Plan
Medical Plan(s) (including prescription drugs and mental health and chemical dependency treatment)	Plans **A, B, R and Flat Rate** all offer a choice between the: • Indemnity Medical Plan; or • Kaiser HMO Plan Within each choice, the medical benefits will be slightly different for each Plan option. Please note: • Kaiser Participants have their prescription drug coverage through Kaiser HMO. • Indemnity Medical Plan Participants have prescription drug coverage through Express Scripts PBM.			
Hearing Aid	For Participants and eligible Dependents in Plans A, B, R and Flat Rate who are enrolled in the Indemnity Medical Plan. Kaiser Participants have their hearing aid benefits through Kaiser HMO.			
Member Assistance Program (MAP)	Yes	Yes	Yes	Yes
Dental Plan	Yes	Yes	Yes	Yes
Orthodontic (eligible children under age 19)	Yes	Yes	Yes	Yes

Type of Benefit	Plan A	Plan B	Plan R	Flat Rate Plan
Vision Plan	For Participants and eligible Dependents in Plans A, B, R and Flat Rate who are enrolled in the Indemnity Medical Plan, there is a vision plan available. Kaiser Participants have their vision plan benefits through Kaiser HMO.			
Life Insurance	Yes	Yes	Not applicable	Yes
Accidental Death and Dismemberment (AD&D) Insurance	Yes	Yes	Not Applicable	Yes
Supplemental Weekly Disability Benefits (All Participants except Stakeholders)	Yes	Yes	Yes	Not applicable

International Benefit Option

The International Benefit Option was developed for Participants who have immigrated to the United States but have Dependents remaining in their native countries. Because of difficulties in submitting claims for these Dependents to the Fund, these Participants may purchase health insurance coverage for their Dependents from the governments of their native countries.

- If you elect the International Benefit Option, you (the Participant) will be covered under the Indemnity Medical Plan.
- Your Dependents will not be covered, but you will receive reimbursement for the amount you have paid to a foreign government for your Dependents' health coverage—up to $100 per calendar year per Dependent. You may receive only one reimbursement per eligible Dependent in any period of 12 consecutive months.

For you to qualify for reimbursement:

- You must be eligible for Fund benefits at the time you pay the foreign government for the health insurance;
- Your Dependents must meet the Plan's Dependent eligibility requirements; and
- You must elect Indemnity Medical Plan coverage for yourself.

If you choose this option and then decide you want to cover your Dependents in the United States instead, you may change from the reimbursement arrangement to Dependent coverage under the Fund. Any such change would be subject to the Plan's rules governing the timing of changes in medical plan coverage.

Eligibility for Coverage

Your eligibility requirements are different depending on whether you are covered under Plan A, Plan B, Plan R or the Flat Rate plan. The eligibility requirements for each plan are outlined below.

Eligibility Requirements for Plan A Participants

The eligibility requirements for Plan A Participants are outlined below.

Initial Eligibility

You and your covered Dependents become eligible on the first day of the second calendar month following a period of not more than 6 consecutive calendar months during which you work at least 400 hours for a Contributing Employer. You are eligible for benefits if you work for one or more Contributing Employers and contributions are required to be made to the Fund by a Collective Bargaining Agreement or a Subscriber Agreement. In some cases, if your Employer fails to pay your contributions, your benefits will be delayed or cancelled.

Lag Month

In order for there to be sufficient time for Employer reports to be received and processed by the Trust Fund Office, a "lag month" will be used in determining your monthly eligibility. The lag month is the month between the payroll period in which the hours were worked and the month of eligibility provided by those hours.

Continuation of Eligibility

Hours worked for Contributing Employers are credited to your "Hour Bank." For each month of eligibility, 100 hours are deducted from your Hour Bank (lag month applies). You may accumulate up to a maximum of 600 hours in your Hour Bank. This will provide up to 6 months of future eligibility which is applied toward any COBRA Continuation period.

Cancellation of Hour Bank

Your Hour Bank will be immediately reduced to zero when any of the following events occur:

- You fail to report the existence of other group health coverage (as outlined under the Coordination of Benefits provisions) on any benefit claim form submitted to the Plan.
- You knowingly permit a Contributing Employer to contribute to the Fund for less than all the hours worked for that Employer (except as provided by the Collective Bargaining Agreement).
- You perform a type of work that is covered by a Collective Bargaining Agreement requiring contributions to this Plan for an employer who is not a Contributing Employer.
- Four consecutive months have elapsed in which hours are reported for you and the Employer fails to pay the required contributions.
- If you are eligible for Retiree health coverage under the Trust Fund, the first day of the 4th month following the date of your retirement, regardless of whether or not you elect to enroll for coverage as a Retired Participant or whether you delay enrolling for Retiree health coverage because you have other health coverage available.

Termination of Eligibility

Your eligibility will terminate on the *earlier* of the following dates:

- The first day of the month following exhaustion of coverage provided by your Hour Bank (See "Cancellation of Hour Bank under Plan A " above); or
- The date this Plan is terminated; or
- The first day of the month following the date the Fund is notified that you have performed work other than work under a Collective Bargaining Agreement or Subscriber Agreement requiring contributions to the Fund with respect to that work (defined as "Non-Qualifying Employment"); or
- For Participants enrolled in COBRA Continuation Coverage, the date you fail to make a COBRA payment; or
- The first day of the month in which you become eligible for Retiree Health and Welfare coverage provided by the Fund; or
- When you otherwise fail to meet the eligibility requirements of the Plan.

Reinstatement of Coverage

When your eligibility has terminated, you will again become eligible by satisfying the requirements for Initial Eligibility**.**

If a Participant's eligibility has terminated, his/her eligibility will be reinstated on the first day of the second calendar month following the month in which his/her Hour Bank balance, when combined with the work hours reported during the next 2 months following termination of eligibility, equals at least 100 hours.

A Participant who is Disabled and has exhausted any coverage provided through Disability Extension, will have his/her eligibility reinstated on the first day of the second calendar month after his/her Hour Bank shows a total of at least 100 hours provided those hours were worked within the 4 month period immediately following the month in which he or she is no longer certified Disabled by a Physician.

A Participant who fails to reinstate eligibility must meet requirements of eligibility as a new Participant.

Eligibility Requirements for Plan B Participants

The eligibility requirements for Plan B Participants are outlined below.

Initial Eligibility

You and your covered Dependents become eligible on the first day of the second calendar month following a period of not more than 3 consecutive calendar months during which you work at least 280 hours for a Contributing Employer. You are eligible for benefits if you work for one or more Contributing Employers and contributions are required to be made to the Fund by a Collective Bargaining Agreement or a Subscriber Agreement. In some cases, if your Employer fails to pay your contributions, your benefits will be delayed or cancelled.

Lag Month

In order that there will be sufficient time for Employer reports to be received and processed by the Trust Fund Office, a "lag month" will be used in determining your monthly eligibility. The lag month is the month between the payroll period in which the hours were worked and the month of eligibility provided by those hours.

Continuation of Eligibility

Hours worked for Contributing Employers are credited to your "Hour Bank." For each month of eligibility, 100 hours are deducted from your Hour Bank (lag month applies). You may accumulate up to a maximum of 300 hours in your Hour Bank. This will provide up to 3 months of future eligibility which is applied toward your COBRA Continuation period.

Cancellation of Hour Bank

Your Hour Bank will be immediately reduced to zero when any of the following events occur:

- You fail to report the existence of other group health coverage (as outlined under the Coordination of Benefits provisions) on any benefit claim form submitted to the Plan.
- You knowingly permit a Contributing Employer to contribute to the Fund for less than all the hours worked for that Employer (except as provided by the Collective Bargaining Agreement).
- You perform a type of work that is covered by a Collective Bargaining Agreement requiring contributions to this Plan for an employer who is NOT a Contributing Employer.
- Four consecutive months have elapsed in which hours are reported for you and the Employer fails to pay the required contributions.
- If you are eligible for Retiree health coverage under the Trust Fund, the first day of the 4th month following the date of your retirement, regardless of whether or not you elect to enroll for coverage as a Retired Participant or whether you delay enrolling for Retiree health coverage because you have other health coverage available.

Termination of Eligibility

Your eligibility will terminate on the *earliest* of the following dates:

- The first day of the month following exhaustion of coverage provided by your Hour Bank (See "Cancellation of Hour Bank under Plan B" above); or
- The date this Plan is terminated; or
- The first day of the month following the date the Fund is notified that you have performed work other than work under a Collective Bargaining Agreement or Subscriber Agreement requiring contributions to the Fund with respect to that work (defined as "Non-Qualifying Employment"); or
- For Participants enrolled in COBRA Continuation Coverage, the date you fail to make a COBRA payment; or
- The first day of the month in which you become eligible for Retiree Health and Welfare coverage provided by the Fund; or
- When you otherwise fail to meet the eligibility requirements of the Plan.

Reinstatement of Coverage

When your eligibility has terminated, you will again become eligible by satisfying the requirements for Initial Eligibility.

Eligibility Requirements for Plan R Participants

The eligibility requirements for Plan R Participants are outlined below.

Initial Eligibility

You and your covered Dependents will become eligible on the first day of the second calendar month following the month in which you work at least 110 hours for a Contributing Employer. You are eligible for benefits (except life insurance and accidental death and dismemberment benefits) if you work for one or more Contributing Employers and contributions are required to be made to the Fund by a Collective Bargaining Agreement or a Subscriber Agreement. In some cases, if your Employer fails to pay your contributions, your benefits will be delayed or cancelled.

Lag Month

In order that there will be sufficient time for Employer reports to be received and processed by the Trust Fund Office, a "lag month" will be used in determining your monthly eligibility. The lag month is the month between the payroll period in which the hours were worked and the month of eligibility provided by those hours.

Continuation of Eligibility

Once eligibility is established, you will continue to be eligible for each month in which you work at least 110 hours for a Contributing Employer, provided your Employer makes the required contributions to the Fund on your behalf (lag month applies).

Termination of Eligibility

Your eligibility will terminate on the *earliest* of the following dates:

- The last day of the month following the month in which you did not work a minimum of 110 hours for a Contributing Employer; or
- The date this Plan is terminated; or
- The first day of the month following the date the Fund is notified that you have performed work other than work under a Collective Bargaining Agreement or Subscriber Agreement requiring contributions to the Fund with respect to that work (defined as "Non-Qualifying Employment"); or
- For Participants enrolled in COBRA Continuation Coverage, the date you fail to make a COBRA payment; or
- The first day of the month in which you become eligible for Retiree Health and Welfare coverage provided by the Fund; or
- When you otherwise fail to meet the eligibility requirements of the Plan.

Reinstatement of Coverage

When your eligibility has terminated, you will again become eligible by satisfying the requirements for Initial Eligibility.

Eligibility Requirements for Flat Rate Participants

The eligibility requirements for the Flat Rate plan are outlined below.

Initial Eligibility

If you are a full-time, Flat Rate Participant of a Contributing Employer who has signed a Subscriber Agreement to provide the Flat Rate Plan, you and your covered Dependents will become eligible on the first day of the 4th calendar month following your date of hire. Salaried non-bargaining unit Participants become eligible for coverage on the first day of the month immediately following the date of hire. Non-salaried full-time non-bargaining Participants become eligible for coverage on the first day of the fourth month following their date of hire. You will be eligible for all benefits except supplemental weekly disability benefits.

A full-time, Flat Rate Participant is defined as a Participant who is employed by a Contributing Employer in work not covered by a construction industry Collective Bargaining Agreement and who works a minimum of 17.5 hours per week within the 46 Northern California Counties.

Lag Month

The Flat Rate Plan does not have a lag month as described in Plans A, B and R. For the Flat Rate Plan, contributions for coverage are paid each month proceeding the month of eligibility.

Continuation of Eligibility

Once eligibility is established, your eligibility for coverage will continue if you work a minimum of 17.5 hours per week and your Employer continues to make the required contributions to the Fund on your behalf.

Termination of Eligibility

Your eligibility will terminate on the *earliest* of the following dates:

- The last day of the month following the month in which you terminate employment with an Individual employer; or
- The day your Employer fails to remit full health and welfare contributions; or
- The date this Plan is terminated; or
- The first day of the month following the date the Fund is notified that you have performed work other than work under a Collective Bargaining Agreement or Subscriber Agreement requiring contributions to the Fund with respect to that work (defined as "Non-Qualifying Employment"); or
- For Participants enrolled in COBRA Continuation Coverage, the date you fail to make a COBRA payment; or
- The first day of the month in which you become eligible for Retiree Health and Welfare coverage provided by the Fund; or
- When you otherwise fail to meet the eligibility requirements of the Plan.

Eligibility Requirements for Stakeholders

A Stakeholder is a person who is an owner, partner, shareholder, member of the board of directors of a corporation, officer of an individual employer, superintendent above the rank of foreman or general foreman, or other individual who is in any other way interested in the profits of the employer– other than hourly wages earned or paid pursuant to a collective bargaining agreement.

The eligibility requirements for Stakeholders are outlined below. Please note that a Stakeholder **is not eligible** for Disability Extension benefits, Supplemental Weekly Disability benefits or COBRA Continuation coverage.

Initial Eligibility

If you are a Stakeholder, eligibility will be granted only if:

- All contributions due on behalf of all hours for all Participants are current; and
- All delinquencies are resolved.

Hours reported on behalf of a Stakeholder must equal or exceed an average of 145 hours during the three most current work months.

Continuation of Eligibility

You must equal or exceed an average of 145 hours during the three most current work months in order to have continued eligibility.

Cancellation of Hour Bank

If you are performing work covered under a Collective Bargaining Agreement, your Hour Bank will be immediately reduced to zero when any of the following events occur:

- The first day of the second calendar month which follows a period of not more than three consecutive calendar months during which she/he averaged less than 145 work hours per month.
- The first day of the month following the employer's failure to resolve delinquencies or remit all contributions due on behalf of all hours reported for all Participants.
- If following a period when previously reported as a Stakeholder, the employer stops reporting hours for such individual who remains in the employ of the employer in any capacity, the first day of the second calendar month.

Termination of Eligibility

The eligibility of a Stakeholder will terminate on the earliest of the following dates:

- The first day of the month following exhaustion of coverage provided by your Hour Bank; or
- The day your Employer fails to remit full health and welfare contributions; or
- The date this Plan is terminated; or
- The first day of the month following the date the Fund is notified that you have performed work other than work under a Collective Bargaining Agreement or Subscriber Agreement requiring contributions to the Fund with respect to that work (defined as "Non-Qualifying Employment"); or
- For Participants enrolled in COBRA Continuation Coverage, the date you fail to make a COBRA payment; or
- The first day of the month in which you become eligible for Retiree Health and Welfare coverage provided by the Fund; or
- When you otherwise fail to meet the eligibility requirements of the Plan; or
- If performing work covered under a Collective Bargaining Agreement, eligibility will end on the first day of the second calendar month which follows a period of not more than three consecutive calendar months during which he/she averaged less than 145 work hours per month; or
- The first day of the month following the employer's failure to resolve delinquencies or remit all contributions due on behalf of all hours reported for all employees; or
- If following a period of having hours reported by an individual employer as a Stakeholder, the employer stops reporting hours for such individual who remains employed by the employer in any capacity, the first day of the second calendar month.

Disability Extension for Plan A, Plan B and Plan R

If you become temporarily Disabled while covered under the Plan (as defined in the Definition Chapter), you may qualify for an **extension of eligibility.** An eligible Participant in Plan A may qualify for up to 9 months of extended eligibility within the 24-month period. Eligible Participants in Plan R and Plan B may qualify for up to 4 months of extension of eligibility. Flat Rate Participants and Stakeholders are not eligible for this extension of eligibility.

- To qualify for this disability extension, you must file an application with the Trust Fund Office **no later than 12 months from the First Day of Disability.**
- If your application is approved, a disability extension may then be given to extend **existing** eligibility (up to a maximum of 4 months for Plan R and Plan B or 9 months for Plan A) but not to establish eligibility.

The "lag month" applies. Therefore, in order to qualify for the disability extension, you must have eligibility for the month in which you become Disabled ***and*** for the following month.

For example, if you are eligible in April and disabled in April and you have at least 100 hours remaining in your Hour Bank to be deducted for May coverage, you may receive the Disability Extension to extend your Hour Bank for an additional month (for June coverage). However, if there are less than 100 hours in your Hour Bank and you would not be eligible for May, no Disability Extension would be granted.

The Disability Extension will **not** be provided for the following:

- A Participant who has not been eligible under Plan A, B or R for a minimum of 12 calendar months, based on work hours or an hour bank deduction from bank hours accrued as a result of work hours (not a disability extension), within the 24 calendar months immediately preceding the First Day of Disability, as defined in the Definitions section of this SPD.
- More than 9 months (Plan A) and more than 4 months (Plans B and R) within the 24 month period.
- Any Period of Disability for which evidence of receipt of Workers' Compensation Benefits or State Disability Insurance Benefits has not been furnished to the Fund.
- A Disability for which the Plan has not received notice of claim within 12 months of the First Day of Disability (as defined).
- Any Period of Disability which begins while the Participant is receiving Continuation Coverage under COBRA.
- A Participant who has not worked for a Contributing Employer at least one day within the 30 day period preceding the First Day of Disability.
- Stakeholders are not eligible for the Disability Extension of benefits.

If you become disabled, you should immediately remit a Certificate of Disability form to the Trust Fund Office for consideration. You may contact the Trust Fund Office by phone to request the form or go online at www.carpenterfunds.com.

A Participant who does not reside in a state that provides State Disability Insurance Benefits is also eligible for the benefit outlined above if you provide the Plan with written certification from a Physician approved by the Plan showing that you are Disabled as defined by the Plan.

Coverage may terminate before the above dates if:

- A Participant progresses from temporary disability to permanent disability; or
- A Participant ceases to be disabled.

Indemnity Plan Extension of Benefits for Disability

If coverage terminates while an Eligible Individual is Disabled, Indemnity Medical Plan benefits will be temporarily extended for Covered Expenses incurred after the date of termination. These extended benefits are subject to the same terms that would have applied if this coverage had remained in force. These extended benefits are payable only for Covered Expenses incurred:

- For treatment of the specific Illness or Injury that caused the Disability; and
- While the person remains Disabled; and
- During the first 6 months after the date this coverage terminates.

For purposes of this provision the term "Disabled" means:

- For a Participant, that the Participant is unable to engage in any employment for wages or profit; or
- For a Dependent, that the Dependent is prevented by the Disability from engaging in the regular and customary activities usual for a person of similar age and family status.

Stakeholders are not eligible for the Indemnity extension of benefits for Disability.

Dependents' Eligibility

If you elect coverage for yourself, you are also eligible for medical, dental and vision coverage for your eligible Dependents on the later of the day you become eligible for your own coverage or the day you acquire an eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have submitted a completed written enrollment form that may be obtained from the Trust Fund Office and provided the Plan's required proof of Dependent status is received by the Trust Fund Office.

A Dependent may not be enrolled for coverage unless the Participant is also enrolled. Specific documentation to substantiate Dependent status will be required by the Plan. An eligible Dependent includes:

- Your lawful spouse;
- Your Qualified Domestic Partner (as defined below).
- Your child who is:
  (1) a natural child, stepchild, legally adopted child, or a child that is required to be covered under a Qualified Medical Child Support Order or National Medical Support Notice, who is younger than 26 years of age, whether married or unmarried. Adopted children are eligible under the Plan when they are placed for adoption.

  Please note: The limiting age for Orthodontic coverage for all Dependent child(ren) is up to age 19.

  (2) an unmarried child for whom you have been appointed legal guardian, provided the child is younger than 19 years of age and is considered your dependent for federal income tax purposes;
  (3) an unmarried child of your qualified Domestic Partner, provided the child is younger than 19 years of age and is primarily dependent on you for financial support;
  (4) an unmarried child eligible under paragraph (2) or (3) above who is at least 19 but less than 23 years of age and a full time student at an accredited educational institution, provided the child otherwise meets the requirements of paragraph (2) or (3) above; or
  (5) an unmarried child of you or your spouse or qualified Domestic Partner of any age who is prevented from earning a living because of mental or physical disability, provided the child was disabled and eligible as a Dependent under this Plan before reaching the limiting age described in paragraphs (1), (2), (3) or (4) above, and provided the child is primarily dependent on the Participant for financial support.

For Children of a Domestic Partner or Children who are required to be covered under a legal guardianship: If the Plan receives a written certification from a child's treating Physician that (1) the child is suffering from a serious illness or injury, and (2) a leave of absence (or other change in enrollment) from a postsecondary institution is Medically Necessary, and if the loss of student status would result in a loss of health coverage under the Plan, the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the Medically Necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (i) one year later, or (ii) the date on which coverage would otherwise terminate under the terms of the Plan (for example, when the child reaches the Plan's limiting age). You or your Dependent must submit a Physician's certification of the medical necessity for the leave to the Trust Fund Office at least 30 days prior to the medical leave of absence if it is foreseeable, or 30 days after the start of the leave of absence in any other case.

Qualified Medical Child Support Orders (QMCSO): In accordance with ERISA Section 609(a), the Fund will provide coverage for a child of a Participant if required by a Qualified Medical Child Support Order, including a National Medical Support Notice (NMSN). A QMCSO or NMSN will supersede any requirements in the Plan's definition of Dependent stated above. The Plan will enroll as directed by the Order any child of a Plan Participant specified by the Order. A *Qualified Medical Child Support Order* is any judgment, decree or order (including approval of a domestic relations settlement agreement or National Medical Support Notice) issued by a court that:

- Provides the child of a Plan Participant with child support or directs the Participant to provide the child with coverage under a health benefits plan, or
- Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Participant parent does not enroll the child, then the non-Participant parent or State agency may enroll the child.
- A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

When in receipt of a QMCSO or NMSN, the Fund is required to enroll the child(ren) in the Plan.

No eligible Participant's child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's federal income tax return or does not reside with the parent.

Procedures governing QMCSO are available from the Trust Fund Office.

Qualified Domestic Partners*:* The term "Qualified Domestic Partner" means a person who resides with the Participant in the same residence, is at least 18 years of age and whose relationship with the Participant meets the following requirements:

- The Domestic Partner and the Participant have an intimate, committed relationship of mutual caring for a period of at least 6 months and are each other's sole domestic partner;
- The Domestic Partner and the Participant share joint responsibility for each other's common welfare and financial obligations and can submit proof of that relationship as required by the Board of Trustees;
- Neither the Domestic Partner nor the Participant is married;
- The Domestic Partner and the Participant are each competent to contract;
- The Domestic Partner and the Participant are not related by blood closer than would prohibit legal marriage in the State of California;
- Any prior domestic partnership of either person has been terminated at least 6 months prior to the date of the signing of the final declaration of domestic partnership with the Trust Office; and
- Application for domestic partnership with the Participant is properly made as required by the Board of Trustees.

Termination of a Dependent's Eligibility

- On the date the Participant's eligibility terminates or, in the event of the death of the Participant, on the date his or her eligibility would have terminated but for this death; or
- On the date he or she no longer qualifies as a Dependent, except that eligibility for Dependent natural children, stepchildren and legally adopted children will terminate at the end of the month in which the Dependent turns age 26.

Special Enrollment

Newly Acquired Spouse and/or Dependent Child(ren)

- If you acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your new Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)
- **If you did not enroll your Spouse for coverage** within 31 days of the date on which he or she became eligible for coverage under this Plan, and if you subsequently acquire a Dependent Child(ren) by birth, adoption or placement for adoption or marriage, and you are eligible for coverage, you may request enrollment for your Spouse and/or your new Dependent Child(ren) and/or any Dependent Child(ren) no later than 31 days after the date of your new Dependent Child(ren)'s birth, adoption or placement for adoption.

Loss of Other Coverage

If, you did not request enrollment under this Plan for yourself, your Spouse, and/or any Dependent Child(ren) within **31 days** after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program) **and** you, your Spouse and/or any Dependent Child(ren) **loses coverage** under that other group health plan or health insurance policy; and you are eligible for coverage under this Plan, you may request enrollment for yourself and/or your Spouse and/or any Dependent Child(ren) within **31 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Participant to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered.

COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 18-month, 29-month or 36-month (as applicable) period of COBRA Continuation Coverage has expired.

Medicaid Or A State Children's Health Insurance Program (CHIP):

When you are eligible for benefits under this Plan, you and your dependents **may also enroll in this Plan** if you (or your eligible dependents):

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or
- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

- **Coverage of an individual enrolling because of loss of other coverage or because of marriage:** If the individual requests Special Enrollment within 31 days of the date of the event that created the Special Enrollment opportunity, (except for a newborn, newly adopted child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), (discussed below) generally coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.
- If the individual requests enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.

- **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 31 days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options at the same costs and the same enrollment requirements as are available to similarly-situated Participants at Initial Enrollment.

Family and/or Medical Leave (FMLA) or other Mandated Leave

If your Employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA) or other mandated leave, you and your eligible Dependents will continue to be covered under this Plan provided you were eligible when the leave began and your Employer makes the required contributions to the Fund during the leave. When an Employer approves a leave of absence under FMLA, the contribution due is the amount required by the collective bargaining agreement for 7 hours per work day for the period of the leave.

It is not the role of the Fund to determine whether or not you are entitled to FMLA leave with medical coverage. Any questions regarding entitlement to FMLA leave with continued medical benefits must be resolved with your Employer at the time you request FMLA leave.

Military Service

If you enter military service with the Uniformed Services of the United States, you may continue your eligibility under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), provided you were eligible under the Plan when your military service began. The term "Uniformed Services" means the Armed Services (including the Coast Guard), 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 Service, and any other category of persons designated by the President in time of war or emergency.

Continuation of Eligibility

- If your period of military service is less than 31 days, your eligibility will be continued during the period of military service with no self-payment required.
- If your period of military service is 31 days or more, you may continue your eligibility for up to 24 months but you will be required to make self-payments for this continued coverage. During the first 18 months of USERRA continuation coverage you will have the same rights as if you had elected "Continuation Coverage Under COBRA". However, COBRA provisions, such as the right to elect additional months of coverage in the event of a second qualifying event or a Social Security disability determination do not apply during the last 6 months of the 24-month period. (Note: USERRA continuation coverage is an alternative to COBRA coverage; it runs simultaneously with COBRA coverage, not consecutively.)

Benefits are not provided for an Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, your military service.

Freezing of Hour Bank for Plan A and Plan B Participants

If you are in Plan A or Plan B and you elect to self-pay for coverage during your military service, or if you choose not be covered by the Fund during your service, your Hour Bank will be frozen. (You may also use your Hour Bank to continue Fund coverage during your service. If you do this, no charge will be made for the period of coverage provided by the Hour Bank.) **Please note that this provision does not apply to Participants enrolled in Plan R or the Flat Rate Plans as those Plans do not include Hour Bank eligibility.**

At the end of your military service you will be entitled to eligibility based on the hours in your frozen Hour Bank, provided you return to work for a Contributing Employer in the 46 Northern California counties within the time frames outlined below under "Reinstatement of Lost Eligibility after Military Service" and you provide the required written notifications to the Fund.

Requirement to Notify Trust Fund Office of Military Service

You must notify the Trust Fund Office in writing of your entry into military service as soon as possible, but no later than 60 days after your military service begins. Your notice should indicate whether you wish to:

- self-pay to continue Fund coverage during the military service,
- not be covered by the Fund during your military service, or
- use any accumulated hour bank eligibility to continue Fund coverage during your military service (if you are in Plan A).

Reinstatement of Lost Eligibility After Military Service

If your eligibility under the Plan has terminated for any reason during military service, your eligibility will be reinstated upon your return to work with a Contributing Employer in the 46 Northern California counties, provided you return to employment and notify the Fund within:

- 90 days after separation from military service if your service lasted more than 180 days, or
- 14 days after separation from military service if your service lasted 31 to 180 days.

Eligibility will be reinstated without exclusion or waiting period, except that the Plan will not cover Illnesses or Injuries that the Department of Veterans Affairs has determined to be connected to your military service.

Reservists Called to Active Duty (Other Than a Temporary Tour of Duty of 30 Days or Less)

If you are in the military reserves of the Uniformed Services of the United States and you are called to active military duty:

- **if you are in Plan A**, you will have your Hour Bank credited with 100 hours on the first day of each month for the duration of your tour of duty (unless revoked by the Board of Trustees) or
- **if you are in Plan R**, you will continue to be eligible under the Plan for each month of your tour of active military duty (unless revoked by the Board of Trustees).

In either case, you must be eligible under the Plan when you report for active military duty.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Trust Fund Office

Reciprocity—Eligibility for Participants Whose Hours Are Divided Among Funds

Under a reciprocity rule, you may be provided with eligibility if you would otherwise be ineligible for benefits because your hours of employment have been divided between different health and welfare funds. The rule applies only if the *United Brotherhood of Carpenters and Joiners of America Master Reciprocal Agreement for Health and Welfare Funds* has been adopted by the signatory funds (referred to in this section as "Cooperating Funds") in whose jurisdiction you have worked.

Home Fund

The term "Home Fund" means:

- If you are a member of a local union, the Cooperating Fund in which your local union participates by virtue of its collective bargaining agreement with Employers; or
- If you are not a member of a local union, or you are primarily employed within the jurisdiction of a local union other than the one of which you are a member, the Cooperating Fund is that Fund in which you have worked the majority of your hours in the most recent 5 calendar years.

Outside Fund—
The term "Outside Fund" means any Cooperating Fund under which you work that is not your Home Fund.

Contributions

Health and welfare contributions required from Employers will be made at the rate, at the times, in the manner and at the places required in the Collective Bargaining Agreement covering the geographical area where you actually perform work.

Transfer of Contributions to Home Fund

Participants working outside of the area covered by their Home Fund may authorize their Home Fund to request the Outside Fund to transmit to their Home Fund the monies received by the Outside Fund from Employers. If you make such a request, you waive all rights you may have to eligibility for benefits in the Outside Fund. Your request and waiver will continue until you have revoked them in writing and delivered the revocation to your Home Fund. The Home Fund will send a copy of the written revocation to the Outside Fund.

The Home Fund will file with the Outside Fund a photocopy of your waiver and request for transmittal to the Home Fund of employer contributions received by the Outside Fund. As of each quarter ending March 31st, June 30th, September 30th and December 31st, the Outside Fund at its expense will transmit to the Home Fund all monies received on account of your work. The transmittal will be accompanied by an appropriate report. However, no transmittal of payments will be made for a period prior to one calendar year from the date an Outside Fund received your waiver and request.

Eligibility Credit

The eligibility rules of the Cooperating Funds will provide that Participants receive eligibility credits created after the conversion of inbound contributions transferred from an Outside Fund and transmitted to their Home Fund. Credits will only be granted to you by your Home Fund. In determining the amount to be credited, contributions received by a Home Fund from an Outside Fund will be converted to hours based on the contribution rate in effect at the time with the Home Fund.

Change in Home Fund

Situations may arise where a Participant will, because of good cause, change his or her Home Fund. The following rules will apply if you wish to change your Home Fund from one Cooperating Fund to another Cooperating Fund:

- You must make a written request to both the existing Home Fund and the Cooperating Fund that you desire to be designated as your new Home Fund.
- This request must be in a form, and contain any information, required by both Cooperating Funds.
- The change in Home Funds will be effective when approved by both Cooperating Funds.

Options When Coverage Under This Plan Ends

When coverage under this Plan terminates you may have the option to buy temporary continuation of this group health plan coverage by electing COBRA, or you can look into your options to buy an individual insurance policy for health care coverage from the **Health Insurance Marketplace**.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.coveredca.com/ (for residents of California) or www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan.

When coverage under this Plan terminates, remember that you have options to consider in order to avoid the Individual Mandate penalty. For more information on the Individual Mandate, talk with your tax advisor or visit www.healthcare.gov.

COBRA: CONTINUATION OF COVERAGE UNDER FEDERAL LAW

Under the federal law known as "COBRA," you have the right to continue your health coverage. If employment has been terminated or if you have had a reduction in hours of employment which has caused you to lose eligibility, you have experienced a "Qualifying Event" and are, therefore, entitled to an additional 18 months of coverage under the Plan from the date of the Qualifying Event provided election of COBRA and premium payments are submitted in the time limits described in this section.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace** (*the Marketplace helps people without health coverage find and enroll in a health plan, [for California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov*)].

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Qualifying Events

If one of the following events (known as a Qualifying Event) occurs and results in a loss of coverage, you and your eligible Dependents have the right to continue health coverage that was in effect at the time of the Qualifying Event under a federal law known as "COBRA." COBRA Continuation Coverage is available through the Carpenters Health and Welfare Trust Fund for those who qualify. To receive this continuation coverage, you must pay monthly premiums to the Fund.

The following are Qualifying Events:

1. Reporting by your Employer(s) of less than the minimum required work hours for a month to the Fund on your behalf. In the case of a Flat Rate Participant, termination of your employment.
2. Divorce of the Participant and Spouse
3. Death of the Participant
4. The loss of status as a Dependent child

Duration of COBRA Coverage

COBRA coverage can continue for up to 18, 29 or 36 months, depending on the COBRA Qualifying Event:

- **18 Months** - You and/or your Dependents can continue coverage for up to 18 months from the date of the Qualifying Event if you would otherwise lose coverage because less than the minimum work hours were reported for a month on your behalf.
- **29 Months** – An 18-month coverage period can be extended to a total of 29 months if you or your Dependent becomes disabled (as determined by the Social Security Administration) before or during the first 60 days of COBRA coverage. See "Extended COBRA Coverage in Cases of Disability."
- **36 Months** - Each of the other above-listed Qualifying Events (Items 2 through 4) entitles your Dependents to 36 months of coverage from the date of the Qualifying Event. (In the case of a child's losing Dependent status, only the affected child is eligible for 36 months of coverage.)

Extended COBRA Coverage in Cases of Disability

If you and/or your Dependents are entitled to COBRA coverage for an 18-month period, that period can be extended for an eligible person who is determined to be entitled to Social Security Disability Income benefits, and for any other eligible family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage or within the first 60 days of COBRA coverage.

- The disabled person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The Participant, the disabled person or other family member notifies the Trust Fund Office that the determination was received. See "Your Duty to Notify the Trust Fund Office" on page 26 for notification deadlines.

Please note the premium for the additional 11 months will be approximately 50% higher than the premium for the initial 18 months of COBRA coverage.

Extended COBRA Coverage If A Second Qualifying Event Occurs

If, during an 18-month period of COBRA Continuation Coverage resulting from insufficient work hours, the Participant dies, divorces, or if a covered child ceases to be a Dependent child under the Plan, the maximum COBRA coverage period for the affected Spouse and/or child is extended to 36 months from the date of the first Qualifying Event.

This extended period of COBRA coverage is **not** available to anyone who became the Participant's Spouse after the first Qualifying Event. However, this extended period of COBRA coverage is available to any children born to, adopted by, or placed for adoption with the Participant during the 18-month period of COBRA coverage.

See "Your Duty to Notify Trust Fund Office" on page 26 regarding your responsibility to notify the Trust Fund Office that a second qualifying event has occurred.

Effect of Medicare Entitlement Before a Termination of Employment or Reduction in Hours

If you are a Participant and had a COBRA Qualifying Event based on a reduction of hours or in the case of the Flat Rate Plan, termination of employment, within 18 month of becoming entitled to Medicare (Part A, Part B or both), the maximum period of continuation coverage for your Dependents will be 36 months after the date of your Medicare entitlement but your COBRA period will remain 18 months from the Qualifying Event.

Note: Medicare entitlement is not a qualifying event under this plan. Medicare entitlement *after* a Qualifying Event will not extend a Dependent qualified beneficiary's COBRA coverage beyond the 18 month coverage period and your COBRA period will terminate on the Medicare effective date.

Cost of Continuation Coverage – Benefits That May Be Continued

COBRA Continuation Coverage is available only at your own expense. If you or your Dependents elect to continue coverage, the full cost, plus a 2% administrative charge, will be charged (in the case of an extension due to disability, it is the full cost plus 50%).

- You may elect to continue medical and prescription drug coverage only (Core Coverage); or
- Medical, prescription drug, vision and dental coverage (Core Plus Coverage).

For Plan A and B Participants Only: There is no charge for any portion of the COBRA period during which the Trust Fund extends coverage beyond the Qualifying Event, based upon the Hour Bank rules of Plan A or Plan B**.**

- The months of extended coverage resulting from hours remaining in your Hour Bank will subsidize 100% of the cost of your COBRA Continuation Coverage for those months and will count toward the 18-month COBRA Continuation Coverage period.
- In addition to providing Core Plus COBRA Continuation Coverage, the Hour Bank will provide life insurance, accidental death and dismemberment benefits and weekly disability benefits. However, life insurance, accidental death and dismemberment benefits and weekly disability benefits are <u>not</u> included under the COBRA Continuation Coverage that you pay for.

Paying for COBRA Coverage

The Trust Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage and of any monthly COBRA premium amount changes.

- There will be an initial grace period of 45 days to pay the first premium due starting with the date COBRA coverage was elected.
- If you are under Plan A and you elect COBRA coverage while running out Hour Bank coverage, your first premium must be paid within 45 days of the date you elect COBRA coverage, or the first day of the first month after the Hour Bank is exhausted, whichever is later.

If this first payment is not made when due, COBRA coverage will not take effect. After the first payment, subsequent payments are due on the first day of each month.

Premiums: A premium for continuation coverage will be charged to the Participant or Dependents, or both, in amounts established by the Board of Trustees. The premium is payable in monthly installments. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

If you make a payment later than the first day of the coverage month to which it applies, but before the end of the grace period for that month, your benefits under the plan will be suspended as of the first day of the coverage month and then retroactively reinstated (going back to the first day of the coverage month) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

How to Obtain COBRA Continuation Coverage

Your Employer has the responsibility to notify the Trust Fund Office within 30 days of the date coverage would otherwise be lost for one of the following reasons:

- your death or
- termination of employment

The Trust Fund Office will determine when your Employer reports less than the minimum required work hours to the Fund on your behalf.

There will be a grace period of 30 days to pay the monthly premium payments. If payment of the amount due is not made by the end of the applicable grace period, your COBRA coverage will terminate.

The Trust Fund Office has 60 days after it receives written notice from your Employer, or after it determines that less than the minimum required work hours have been reported by your Employer, to notify you of your rights to continue coverage.

Your Duty to Notify Trust Fund Office

You or your dependents are responsible for providing the Trust Fund Office with timely notice of the following qualifying events:

- within 60 days of your (the Participant's) divorce from your spouse,
- within 60 days of loss of dependent status by a child, or
- within the first 18 months of continuation coverage if your Dependent has a second Qualifying Event.

You must also provide the Trust Fund Office with timely written notice

- Within 60 days after receipt of a Social Security Administration determination of disability, or
- Within 30 days after the Social Security Administration determines that the person is no longer disabled.

You or your Dependents should advise the Trust Fund Office of these events as well to ensure prompt handling of COBRA rights.

Note: Failure to provide this notice within these time frames may prevent you and/or your Dependents from obtaining or extending COBRA coverage.

You must make sure that the Trust Fund Office is notified of any of the five occurrences listed above.

How to Notify the Trust Fund Office

Notice of any of the five situations listed above must be given to the Trust Fund Office in writing. Your written notice must contain the following information:

- name of the qualified beneficiary,
- the Participant's name and ID number or social security number,
- the event for which you are providing notice and the date of the event (for example, the date of a dependent child's 26th birthday), and
- a copy of the final marital dissolution if the event is a divorce,
- if your child is no longer a full time student, your letter should include the date he or she last attended school.

If you have any questions about how to notify the Fund of one of these events, please email the Trust Fund Office at benefitservices@carpenterfunds.com or you may call at (510) 633-0333 or (888) 547-2054.

Where to Send Your Notice

Notice of Qualifying Event should be sent to the Trust Fund Office at the following address:

Carpenters Health and Welfare Trust Fund for California
265 Hegenberger Road, Suite 100
Oakland, California 94621-1480
Attention: Benefit Services

You can also e-mail your notice to benefitservices@carpenterfunds.com.

Who Can Notify the Trust Fund Office

Notice may be provided by you or your dependents or any representative acting on behalf of you or your dependents.

Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

Electing Continuation Coverage

After receiving your notice of a qualifying event, the Trust Fund Office will send you a notice of your right to choose continuation coverage with an election form, or, if you do not qualify for continuation coverage, a Notice of Unavailability of COBRA Coverage. These notices will be sent within 60 days of the date the Trust Fund Office receives your notice.

The Trust Fund Office will send you a notice after your Employer reports less than the minimum required work hours for you in a month and it appears your hour bank may be exhausted. For Plan A Participants, the notice will be sent at this time regardless of whether or not you have remaining Hour Bank eligibility. This notice will tell you when your eligibility will terminate and ask you to complete and return the form if you want self-pay COBRA Continuation Coverage beyond the termination of your eligibility.

Even if you think you will be returning to work and will not need COBRA Continuation Coverage, it is very important that you return the election form to the Trust Fund Office within 60 days.

You must sign and return the Election Form to the Trust Fund Office no later than 60 days after the date of your loss of eligibility or the date of the COBRA election Notice from the Trust Fund Office (whichever is later) or you will not be eligible for COBRA Continuation Coverage.

If you do not choose continuation coverage, your Carpenter health insurance coverage will end. However, your Spouse and/or your eligible Dependents may elect continuation coverage, independent of your rejection.

Your initial continuation coverage must be identical to coverage provided to similarly situated Participants under the Plan on the day prior to the Qualifying Event, although it may be modified if coverage changes for other Participants or family members.

In considering whether to elect COBRA Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA Continuation Coverage if you get COBRA Continuation Coverage for the maximum time available to you.

Health Coverage Tax Credit (HCTC)

The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019. For more information, visit, www.irs.gov/HCTC.

Adding New Dependents

If, while you are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, have a child placed with you for adoption, or assume legal guardianship of a child, you may enroll that Spouse or child for coverage for the balance of the period of your continuation coverage, by sending a completed enrollment form to the Trust Fund Office within 30 days after the birth, marriage or placement for adoption.

Special enrollment for the balance of your COBRA period is also allowed for dependents who lose other coverage. For this to occur:

- Your dependent must have been eligible for COBRA coverage on the date of the qualifying event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage,
- Your dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it, and
- You must enroll that dependent by sending an enrollment form to the Trust Fund Office within 30 days after the termination of the other coverage or contributions.

Changing Medical Plans Under COBRA Continuation Coverage

If you wish to change your medical plan, you must meet the same requirement as Plan Participants, meaning you must be in your medical plan for at least 12 months before you can change to a different medical plan. Exceptions are made only if you are enrolled in Kaiser and you move out of its service area or a change is approved by the Board of Trustees. If you are eligible for a change, you may submit a new enrollment form indicating the change to the Trust Fund Office. The change will go into effect the first day of the second calendar month following the date your enrollment form is received by the Fund.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate at the end of the maximum continuation period allowed (18, 29 or 36 months, as applicable). COBRA Continuation Coverage will terminate before the end of the 18, 29 or 36 month period upon the occurrence of any of the following events:

1. You or your Dependents fail to remit the required premium payments in full and on time (within 45 days following the submission of the initial COBRA election form and including the cost of coverage retroactive to the first day your coverage would have otherwise terminated, or within 30 days following the due date for subsequent monthly payments);
2. You or your Dependents become covered under any other group medical plan after the date you elect COBRA coverage;
3. You or your Dependents become entitled to Medicare after the date of your COBRA election (Entitled to Medicare means being eligible to enroll in either Part A or Part B of Medicare, whichever occurs earlier);
4. Your Employer no longer provides group health coverage to any of its Participants; or
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.

COBRA Continuation Coverage will terminate on the first day of the month following events 1 through 5.

If COBRA coverage is terminated before the end of the maximum period of coverage, the Trust Fund Office will send you a written notice as soon as practicable following its determination that continuation coverage will terminate.

Post-COBRA Coverage Under Kaiser – California COBRA Law

If you are a COBRA participant enrolled in Kaiser, California law has a provision that affects the length of time you may continue coverage. This law applies only to your Kaiser medical coverage, not to the other health care benefits usually available under COBRA.

This option applies only to Kaiser members.

- If your Qualifying Event was termination of your employment or reporting of less than the minimum required work hours for a month and you exhaust the 18 months of coverage normally available after such a Qualifying Event (or the 29 months available in the case of disability), you may continue your Kaiser medical coverage for an additional 18 months (or an additional 7 months in the case of a disability).
- To take advantage of this provision, you must remain in the Kaiser plan.

All arrangements for additional months of coverage under the California COBRA law must be made directly with Kaiser. The Fund is not involved.

Check your Kaiser Evidence of Coverage for more information on how to elect post-COBRA extended coverage under California law or enroll in a Kaiser conversion plan. You can also call Kaiser Member Services.

Conversion to Individual Coverage

At the end of the COBRA Continuation Coverage period, you or your eligible Dependents may enroll in any individual conversion plan offered by Kaiser as described in the Kaiser Evidence of Coverage brochure, provided you were enrolled in Kaiser before your continuation coverage ended.

Note: You also have the option to purchase individual conversion coverage from Kaiser instead of COBRA coverage, but only if you were enrolled in Kaiser when your Trust Fund coverage ended.

Keeping the Trust Fund Office Notified

- If you have changed marital status, or you or your Spouse or other Dependents have changed addresses, please contact the Trust Fund Office.
- Please let the Trust Fund Office know of any Qualifying Event even if your Employer is otherwise required to give notice.

COBRA Continuation Coverage–Quick Reference Chart

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
Reduction in your minimum required work hours	You, your Spouse and Dependent children	18 months after date of Qualifying Event*
Termination of your employment	You, your Spouse and Dependent children	18 months after date of Qualifying Event*
Your death	Your Spouse and Dependent children	36 months after date of Qualifying Event
Your divorce	Your former Spouse and Dependent children	36 months after date of Qualifying Event
Your child's loss of Dependent status under Plan	Affected child if covered under Plan	36 months after date of Qualifying Event

* If you or one of your eligible Dependents is disabled, COBRA Continuation Coverage may continue for the disabled person and eligible family members for up to 29 months. **A higher premium will be charged for the additional 11 months of coverage.**

If a second Qualifying Event that would result in a 36-month continuation coverage period occurs within the first 18-month period, COBRA Continuation Coverage for Dependents may be extended for up to a maximum of 36 months from the date of the first Qualifying Event.

Continuation of Coverage for Domestic Partners and Children of Domestic Partners

Eligible Domestic Partners of Participants and eligible children of Domestic Partners who lose eligibility under the Plan may continue Plan coverage through self-payment for a limited period of time. The Domestic Partner and children of the Domestic Partner who lose eligibility under the Plan may continue Plan coverage (except dependent life insurance) when eligibility is lost due to any of the following reasons:

- Reporting by your Employer(s) of less than the minimum required hours to the Fund on your behalf for any month
- Your death
- Termination of the Domestic Partner relationship with you
- Cessation of child's Dependent status under the Plan

Premiums. A premium for continuation coverage will be charged to the Domestic Partner or Dependent child, or both, in amounts established by the Board of Trustees. The premium is payable in monthly installments. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Duration of Domestic Partner Continuation Coverage

- In the case of your reduction in hours or termination of employment, coverage may be continued on a self-payment basis for up to 18 months from the date of the event that resulted in the loss of eligibility.
- In all other circumstances, coverage may be continued for up to 36 months from the date of the event that resulted in loss of eligibility.

Continuation coverage will be terminated before the end of the 18-month or 36-month period upon the occurrence of any of the following events:

- The required premium payment for continuation coverage is not paid when due.
- Your Employer ceases to provide group health coverage to any of its employees.
- The Domestic Partner or Dependent child becomes covered under any other Group Plan (as a participant or otherwise) or becomes entitled to Medicare coverage.

Election and Notice Procedure for Domestic Partner Continuation Coverage

The Domestic Partner or child or both must elect continuation coverage within 60 days after the later of:

- The date of any of the events described above under "Continuation Coverage"; or
- The date of the notice from the Trust Fund Office notifying the individual of his/her right to continuation coverage.

KAISER MEDICAL HMO

If you have your medical, prescription drug and vision benefits with Kaiser Permanente HMO, the following section outlining the Indemnity Medical Plan Benefits does not apply to you. However, you may be eligible for additional benefits through the Fund including:

- Dental Benefits as explained beginning on page 70.
- Orthodontic benefits for Dependent children as explained beginning on page 71.
- Life Insurance and Accidental Death and Dismemberment benefits for A, B and Flat Rate Participants as explained beginning on page 72.
- Member Assistance Program (MAP) as explained below:

If you would like a copy of your Evidence of Coverage (EOC), please contact Kaiser at Member Services at (800) 464-4000 or visit the website, www.kp.org.

Member Assistance Program (MAP)

The Member Assistance Program offers services such as relationship counseling, Legal Assistance, Financial Advice, Identification Recovery, Tobacco Cessation and Dependent Care and Daily Living Resources.

This plan offers up to **4 free face-to-face MAP** counseling visits per incident, per household member at no cost to you as well as free or discounted fees for other services such as Legal Assistance and Financial Advice. The phone number for the MAP program is (800) 999-7222 and the website is www.AnthemEAP.com (Log in with "Carpenters Trust").

Provider Non-Discrimination

Non-grandfathered plans like Kaiser are prohibited from discriminating against a health care provider who is acting within the scope of his/her license or certification under applicable State law. Although Kaiser is not required to contract with all providers, it must not discriminate with respect to coverage of covered expenses provided by a health care provider acting within the scope of his/her license.

Designation of Primary Care Provider and Prior Authorization for Obstetrics and Gynecology (OB-GYN) Services

Kaiser generally requires the designation of a primary care provider. You have the right to designate any primary care provider (PCP) who participates in the Kaiser network and who is available to accept you or your covered dependents. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the primary care providers in the network, contact Kaiser.

Under Kaiser, you do not need prior authorization and/or referral from the Plan or from any other person (including a primary care physician) to receive care from a health care professional who specializes in obstetrics or gynecology. However, the health care professional, may be required to obtain prior authorization for certain services and follow a pre-approved treatment plan, or procedures for making referrals.

INDEMNITY MEDICAL PLAN/MEDICAL NETWORKS

Please note: The benefits in this chapter do not apply to Kaiser HMO enrollees. If you and your eligible Dependents are covered under the Kaiser HMO, please contact Kaiser (at the telephone number on the Quick Reference Chart) for a copy of your Evidence of Coverage (EOC) that outlines your medical benefits under the Kaiser HMO.

Plan Participants may obtain health care services from Contract or Non-Contract providers. But the amount that you pay for such services may vary.

Advisor / Concierge Program

The Plan offers an Advisor service to help you navigate through such things as locating a Contract Provider, assisting you with finding the most efficient imaging, scanning and surgical facilities. They will help you compare quality and costs of many hospitals in your neighborhood, as well as, steer you away from providers that may require personal payments or contracts. For Advisor assistance, call (844) 437-0488.

Preferred Provider Organization (PPO)

The Plan's Preferred Provider Organization (PPO) is a network of Contract Hospitals, Physicians, laboratories and other providers who are located within a service area and who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to PPO Plan participants. If you receive Medically Necessary services or supplies from a Contracted Provider you will pay a smaller Deductible and lower Coinsurance than if you received those Medically Necessary services or supplies from a provider who is not a Contract Provider. Also, the Contract Provider has agreed to accept the Plan's payment plus any applicable Coinsurance that you are responsible for paying as payment in full.

Directories of Contract Providers

A directory of Contract health care providers is available on the internet at www.anthem.com.

IMPORTANT NOTE

Because providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your provider if they are still a Contracted provider or contact the PPO network before you seek services when possible.

For a list of Contract providers:

- Inside California: Anthem (800) 810-2583 or www.anthem.com
- Outside California: Blue Card (800) 810-2583 or www.bcbs.com or

Contract and Non-Contract Providers

Contract Providers

If you receive medical services or supplies from a provider that is contracted with the Plan's medical network you will be responsible for paying less money out of your pocket. Providers who are under a contract with the network have agreed to accept the discounted amount the Plan pays for covered services. You will be required to pay the applicable deductibles and coinsurance remaining after Plan benefits are paid up to the discounted amount.

Value Based Facilities

In-patient hospital Plan benefits will be limited to $30,000 for single hip joint replacement or single knee joint replacement surgery. The maximum applies to all hospital facility costs but does not include professional fees such as anesthesia or surgical fees. There are specific PPO hospitals throughout California where these surgeries can be performed which will minimize your out-of-pocket costs beyond the Plan's deductible and coinsurance. If you require hip or knee replacement surgery, visit the Trust Fund Office website at www.carpenterfunds.com or call the Trust Fund Office at (888) 547-2054 for the list of hospitals which can provide services at a lower cost.

Non-Contract Providers

Non-Contract Providers refers to providers who are not contracted with the medical plan's PPO network and who do not generally offer any fee discount to the Participant or to the Plan. These Non-Contract providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due in excess of the Plan's Allowed Charge.

Limited or no benefits will be paid for services provided by a Non-Contract provider who did not complete enrollment in the Medicare program or who did not submit an affidavit to Medicare expressing their decision to opt-out of the Medicare program. The Plan limits Medically Necessary *out-patient* services from Non-Contract Providers who are not registered with the Centers for Medicare & Medicaid Services (CMS) to a maximum allowable charge of $100 per appointment, subject to the non-PPO deductible and coinsurance. Benefits paid *for in-patient* services from a Non-Contract Provider is based on a percentage of that provider's CMS registered fee; there will be no benefits available for in-patient services from a Non-Contract Provider who is not registered with CMS.

To Avoid a Reduction in Benefits

- Use the Plan's Contract Hospitals when you or your eligible Dependents require hospitalization.
- Get a Utilization Review for inpatient Hospital stays, as explained on page 56. If you use a Contract Hospital, the Hospital will take care of the Utilization Review for you. If you use a Non-Contract Hospital, it is your responsibility to make sure Anthem Blue Cross has pre-approved the hospital confinement or your benefits may not be payable.
- Use Contract Physicians, Hospitals, laboratory and radiology facilities and other Contract Providers such as surgical centers and urgent care facilities. By using Contract Providers, you will receive the maximum benefits payable and save yourself and the Plan money.
- If you are an eligible Spouse who works, enroll in your employer's health plan. A Spouse who works and is offered the opportunity to enroll for health coverage through her/his employer must enroll for that coverage or benefits under this Plan will be reduced. **Your Spouse must take the insurance that is offered even if there is a contribution required for that coverage.** The requirement applies to Spouses and Domestic Partners only; not to Dependent children.

If a working spouse does not take coverage offered through his/her employer, the Plan will estimate that the other plan paid 80% of expenses incurred and this Plan will pay up to 20% of the Covered Expenses submitted for payment.

Maximum Allowable Charges Apply for Certain Surgical Procedures

Charges for surgical procedures can vary greatly among hospitals and facilities; yet, there is little evidence of a higher quality of care at a higher cost facility. The Fund will limit the maximum allowable charge for the following six surgical procedures:

1. Routine total hip replacements;
2. Routine total knee replacements;
3. Arthroscopic surgeries at an outpatient Hospital;
4. Cataract surgeries at an outpatient Hospital;
5. Colonoscopies at an outpatient Hospital; and
6. Endoscopies at an outpatient Hospital (on or after January 1, 2017)

The maximum payment is the highest amount your plan will pay for these procedures. Any amount over the maximum will be your responsibility to pay.

Procedure	* Maximum Allowable Charge per Surgery
At an inpatient Hospital	
Routine Total Hip Replacement Surgery	$30,000
Routine Total Knee Replacement Surgery	$30,000
At an Outpatient Hospital (instead of an ambulatory surgical center)	
Arthroscopy	$6,000
Cataract Surgery	$2,000

Procedure	* Maximum Allowable Charge per Surgery
Colonoscopy	$1,500
Endoscopy (on or after January 1, 2017)	$1,000

*Please note: Amounts denied as over the maximum for a procedure will not accumulate toward your Coinsurance Maximum.

Exceptions Process

We realize that there are certain times you may not be able to use a provider, hospital, or outpatient surgery center who has agreed to accept the maximum allowable charge. Therefore, in the following situations, the Fund may make an exception for you.

- Your access to a provider, hospital, or outpatient surgery center that will accept the maximum allowable charge is unavailable or the service cannot be obtained within a reasonable wait time or travel distance; and
- The quality of services for you or your Dependents could be compromised with the provider, hospital, or outpatient surgery center (e.g., if comorbidities present complications or patient safety issues).

Information About The Maximum Allowable Charge

Upon request, the Trust Fund Office will provide you with:

- A list of hospitals that accept the maximum allowable benefit for particular inpatient or outpatient services related to knee and hip replacement surgery;
- A list of providers, hospitals and outpatient surgery centers that will accept a negotiated price above the maximum allowable charge; and
- Information on the process and underlying data used to ensure that an adequate number of providers, hospitals and outpatient surgery centers that accept the maximum allowable charge meet reasonable quality standards.

Exceptions to Non-Contract Provider Deductible and Benefit Payment

The following chart explains the Plan's special reimbursement for services when certain Non-Contract providers are used. The Plan Trustees or its designee determines if and when the following special reimbursement circumstances apply to a claim after the normal claim adjudication processes have been followed/investigated. Allowed charge is defined in the Definitions chapter of this document.

SPECIAL REIMBURSEMENT PROVISIONS	WHAT THE PLAN PAYS (toward eligible claims submitted by a Non-Contract provider)
• If a Non-Contract anesthesiologist or emergency room Physician provides services at a Contract Hospital or Facility • Non-Contract Provider licensed ambulance service • Emergency care in a Non-Contract Hospital when the patient had no choice in the Hospital used due to the Emergency or was admitted to the Hospital directly from the emergency room. However, the Plan may require that the patient be transferred to a Contract Hospital upon the advice of your Physician that the acute emergency period has ended and it is safe to transfer the patient. If the patient remains in a Non-Contract Hospital after the acute emergency period, the Non-Contract Provider Deductible and payment percentage will apply for the period of confinement after the emergency period has ended. • If the service provided is Medically Necessary and not available from a Contract Provider.	As if the care was provided by a Contract Provider including deductible, coinsurance and Coinsurance Maximum. The allowance for bills will be reimbursed according to the Allowed Charge for Non-Contract providers.

Inter-Plan Programs Financial Policies Compliance

Out-of-Area Services

Anthem Blue Cross has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of the Anthem Blue Cross service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem Blue Cross and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Anthem Blue Cross service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. The payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem Blue Cross will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside the Anthem Blue Cross service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Anthem Blue Cross

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem Blue Cross uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price made available to Anthem Blue Cross by the Host Blue.

Covered Services

The Plan will pay benefits for the preventive services specifically listed as covered by the Plan and for Medically Necessary services, supplies, care and treatment that are prescribed, performed or ordered by a Physician for treatment of an Illness or Injury. In addition to information noted in "Indemnity Medical Plan Exclusions," the Plan will not pay benefits for any expenses related to an occupational Injury or Illness.

Generally, **the Plan will not reimburse you for all services**. Usually, you will have to satisfy a Deductible and pay some Coinsurance toward the amounts you incur that are Allowed Charges. However, once you have incurred your maximum Coinsurance Limits each calendar year, no further Coinsurance will be applied for that calendar year for Contract provider services.

Deductibles

The annual Deductible is the amount you must pay toward eligible expenses each calendar year before the Plan begins to pay benefits. Each calendar year, you (and **not** the Plan) are responsible for paying all of your Covered Expenses until you satisfy the annual Deductible. Once the deductible has been satisfied the Plan will begin to pay benefits towards Covered Expenses. There are two types of annual Deductibles: Individual and Family.

- The **Individual Deductible** is the amount one covered person has to pay each year towards Covered Expenses before Plan benefits begin. Deductible amount per calendar year for:
  - ***Contract Providers*** - $128 per person, not to exceed $256 per family
  - ***Non-Contract Providers*** - $257 per person, not to exceed $514 per family
- The **Family Deductible** is the amount that a family of two or more persons is responsible for paying each year towards Covered Expenses before Plan benefits begin.

The Deductible does not apply to prescription drug benefits and certain other expenses as outlined in the Schedule of Medical benefits.

Coinsurance

Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible, the Plan generally pays a percentage of the Covered Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the coinsurance.

The Plan's coverage of adult children over the age of 18 does not create any parental responsibility to providers for Coinsurance, Deductibles or otherwise unpaid services provided to an adult child.

Coinsurance Maximum

Each Calendar Year, after an individual or family has incurred a Coinsurance Maximum as outlined in the Schedule of Medical Benefits, no further coinsurance will apply to Covered Expenses by Contract Providers. As a result, the Plan will pay 100% of Covered Expenses during the remainder of the Calendar Year **except for** the expenses that do not accumulate to your coinsurance maximum as listed below. For expenses incurred by Non-Contract Providers, you will have no Coinsurance Maximum.

Expenses That Do Not Accumulate to Your Coinsurance Maximum

This Plan rarely pays benefits equal to **all** the medical expenses you may incur. You are often responsible for paying for certain expenses for medical services and supplies yourself. Under the Plan, each year, you will be responsible for paying the following expenses out of your own pocket **and** these expenses do not accumulate to meet your Coinsurance Maximum:

- Premiums.
- Balance-billed charges.
- Any plan Deductible.
- All expenses for medical services or supplies that are not covered by the Plan.
- All charges in excess of the Allowed Charge determined by the Plan.
- All charges in excess of the Plan's Maximum Benefits, or in excess of any other limitation of the Plan.
- Any additional other amounts you have to pay because you failed to comply with the Utilization Review requirements of the Plan.
- Prescription drugs (including any copay and/or coinsurance amounts).
- Expenses incurred by Non-Contract Providers.
- Amounts from a Non-Contract Provider that exceed the rate filed with Medicare.

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS

A schedule of the medical benefits for the Indemnity Medical Plan appears on the following pages in a chart format. Each of the Plan's medical benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided by Contract Providers and Non-Contract Providers are shown in the subsequent columns.

Please note: the benefits in the following Schedule of Benefits do not apply to Kaiser HMO Participants. If you and your eligible Dependents are covered under the Kaiser HMO, please contact Kaiser (at the telephone number on the Quick Reference Chart) for a copy of your EOC that outlines the medical benefits available under Kaiser HMO.

Deductibles, Coinsurance Maximum, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services are listed first because these categories of benefits apply to most (but not all) health care services covered by the Plan. Unless there is a specific statement in the Schedule of Medical Benefits, all benefits shown are subject to the Plan's Deductibles.

Here are a few tips to make experiences both successful and affordable using the Indemnity Medical Plan

- No matter what kind of treatment you are seeking, always confirm whether providers are PPO contract providers to receive the best benefit possible under the Plan. You can locate a contract provider or determine if your current provider is a contract provider by visiting Anthem's website, www.anthem.com. Click on "Find a Doctor" and select the type of provider and location you are seeking a doctor or; type in your current provider's name to verify their participation in the network. You can also contact the Trust Fund Office for assistance. Email the Trust Fund Office at benefitservices@carpenterfunds.com or call (888) 547-2054.
- Use the Advisor service to help avoid paying unnecessary personal medical bills and reduce your personal costs. For Advisor assistance, call (844) 437-0488.
- Register at **www.anthem.com** with a username and password. When you login, you can use the Anthem Care Comparison tool to research the cost and quality of procedures performed by facilities near you. For example, a colonoscopy can cost anywhere from $450 to $3,000 or, one provider may have more experience performing that procedure than another provider.

  While you are logged in to **www.anthem.com**, you can look for special offers that may help your recovery or overall wellness such as weight loss programs, hearing aids or gym memberships.
- If your doctor ever recommends care for you that requires the services of several different providers, or if your doctor recommends you receive services from another provider or facility altogether, be sure to ask whether the new provider is in the PPO network.

Surgery

- When you make an appointment to see a surgeon, ask if the doctor participates in the PPO network.
- If you have surgery, find out if an assistant surgeon, anesthesiologist physician or a certified registered nurse anesthetist will be involved. If an assistant surgeon will be involved, call the Trust Fund Office. The Trust Fund Office can check to see if the assistant surgeon's involvement is necessary and inform you of any additional out-of-pocket expenses you may incur if the provider's billed charges exceed the Plan's allowance.
- Some surgeries such as colonoscopy, arthroscopy, endoscopy (on or after January 1, 2017) and cataract surgery have specific dollar limits if you use an out-patient hospital instead of an ambulatory surgery center. Using a Contract ambulatory surgery center for these surgeries can greatly reduce your out-of-pocket expense.
- There are also specific Plan maximum benefits for hospital charges if you have a knee or hip replacement surgery. To reduce your out-of-pocket expense for a knee or hip replacement surgery use one of the specific Value Based hospitals for services. You can view the list of Value Based hospitals on the Trust Fund Office website: www.carpenterfunds.com.

Laboratory and Pathology Tests

- When you need laboratory or pathology tests performed, ask your doctor if you can use an independent contract laboratory for services. Services at these independent labs can cost 70%-75% less than the same services provided by hospital-based facilities and non-network laboratories.

For help finding the nearest contract laboratory, visit **www.anthem.com.**

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

You must submit all other health care claims within 90 days of when expenses are incurred, unless it is not reasonably possible to do so. **In no event will claims be paid if they are submitted more than 1 year after the date the expenses were incurred**. The claim form must be completed in full, and an itemized bill or bills and documentation supporting your claim must be attached.

See also the Claims and Appeals Procedures chapter for more information beginning on page 81. Also review the section toward the end of that chapter on "Limitation On When A Lawsuit May Be Started" (on page 87).

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
<u>Deductible</u> • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits. • Deductibles are applied to Covered Expenses in the order in which claims are processed by the Plan. • Only Covered Expenses can be used to satisfy the Plan's Deductibles. • The deductible applies to all covered services except where otherwise noted in this Schedule of Medical Benefits.	• Amounts cross-accumulate between Contract and Non-Contract Providers–for example, a payment of $50 to a Non-Contract Provider for Covered Expenses would count toward the $128 Deductible for Contract Providers. • Charges exceeding any Plan limits on specific benefits and any amounts you pay for failure to comply with the Plan's requirements for Utilization Review do not count toward the deductible.	$128 per person $256 per family	$257 per person $514 per family	$128 per person $256 per family	$257 per person $514 per family
<u>Coinsurance Maximum</u> The Coinsurance Maximum is the most you pay during a one year period (the plan year) before your plan starts to pay 100% for Covered Expenses from Contract providers.	The following do not count toward the Coinsurance Maximum: • Amounts you pay that are counted toward the Deductible • Amounts you pay for expenses or services that are not covered by the Plan • Charges in excess of benefit limits or Plan maximums (such as the amounts over the plan's chiropractic maximum of $25/visit, the acupuncture limit, hearing aid, hospice care, and routine physical examination limits).	$1,289 per person $2,578 per family	No Coinsurance Maximum	$6,445 per person $12,890 per family	No Coinsurance Maximum

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Hospital Services (Inpatient) Room & board and ancillary facility fees • In a Non-Contract Hospital, a room with 2 or more beds is covered (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used). • In a Contract Hospital, the contract rate is covered. • Specialty care units within the hospital (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services.	• Failure to comply with the Plan's requirements for Utilization Review and notification of an emergency admission may result in a reduction in benefits and increase your out-of-pocket costs. • A maximum of $30,000 is payable for the hospital facility associated with a single hip joint or a single knee joint replacement surgery. • Take-home drugs dispensed by a Non-Contract facility are not covered. • Newborn nursery charges are not covered at a Non-Contract facility.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Hospital Surgical Services (Outpatient) For certain surgeries performed in an outpatient hospital instead of an ambulatory service center	• For the Contract and Non-Contract hospital/facility charge a maximum of $6,000 is payable for an arthroscopy, $2,000 for cataract surgery, $1,500 for colonoscopy and $1,000 for endoscopy (for an endoscopy performed on or after January 1, 2017).	Arthroscopy: Plan Pays 90% up to a maximum payment of $6,000 You Pay 10% and any amount over the Plan maximum payment of $6,000 Cataract Surgery Plan Pays 90% up to a maximum payment of $2,000 You Pay 10% and any amount over the Plan maximum payment of $2,000 Colonoscopy Plan Pays 90% up to a maximum payment of $1,500 You Pay 10% and any amount over the Plan maximum payment of $1,500 Endoscopy Plan pays 90% up to a maximum payment of $1,000 You pay 10% and any amount over the Plan maximum payment of $1,000	Arthroscopy: Plan Pays 70% up to a maximum payment of $6,000 You Pay 30% and any amount over the Plan maximum payment of $6,000 Cataract Surgery Plan Pays 70% up to a maximum payment of $2,000 You Pay 30% and any amount over the Plan maximum payment of $2,000 Colonoscopy Plan Pays 70% up to a maximum payment of $1,500 You Pay 30% and any amount over the Plan maximum payment of $1,500 Endoscopy Plan pays 70% up to a maximum payment of $1,000 You pay 30% and any amount over the Plan maximum payment of $1,000	Arthroscopy: Plan Pays 80% up to a maximum payment of $6,000 You Pay 20% and any amount over the Plan maximum payment of $6,000 Cataract Surgery Plan Pays 80% up to a maximum payment of $2,000 You Pay 20% and any amount over the Plan maximum payment of $2,000 Colonoscopy Plan Pays 80% up to a maximum payment of $1,500 You Pay 20% and any amount over the Plan maximum payment of $1,500 Endoscopy Plan pays 80% up to a maximum payment of $1,000 You pay 20% and any amount over the Plan maximum payment of $1,000	Arthroscopy: Plan Pays 60% up to a maximum payment of $6,000 You Pay 40% and any amount over the Plan maximum payment of $6,000 Cataract Surgery Plan Pays 60% up to a maximum payment of $2,000 You Pay 40% and any amount over the Plan maximum payment of $2,000 Colonoscopy Plan Pays 60% up to a maximum payment of $1,500 You Pay 40% and any amount over the Plan maximum payment of $1,500 Endoscopy Plan pays 60% up to a maximum payment of $1,000 You pay 40% and any amount over the Plan maximum payment of $1,000

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Emergency Room Facility • Hospital emergency room (ER) if services are for an Emergency (as that term is defined in this Plan). • Ancillary charges (such as lab or x-ray) performed during the Emergency Room visit. • (See also the Ambulance section of this schedule.)	For a subsequent inpatient confinement (after treatment in an Emergency Room at a Non-Contract Hospital), the Plan may require that the Patient transfer to a Contract Hospital upon the advice of a Physician that it is medically safe to transfer the Patient and the acute Emergency period has ended. If the Patient remains in the Non-Contract Hospital after the acute Emergency period, any Allowed Charges will be payable at the Non-Contract rate for the period of confinement after the Emergency period has ended.	Plan Pays 90% You Pay 10% Plan Pays 100% if emergency treatment is for mental health or chemical dependency	Plan Pays 70% You Pay 30% except when the Eligible Individual has no choice in the Hospital used due to an Emergency, the benefit payable is 90% of the Allowed Charge Plan Pays 100% of the Allowed Charge if emergency treatment is for mental health or chemical dependency	Plan Pays 80% You Pay 20% Plan Pays 100% if emergency treatment is for mental health or chemical dependency	Plan Pays 60% You Pay 40% except when the Eligible Individual has no choice in the Hospital used due to an Emergency, the benefit payable is 80% of the Allowed Charge Plan Pays 100% of the Allowed Charge if emergency treatment is for mental health or chemical dependency

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers

<u>Physician and Other Health Care Practitioner Services</u>
• Physician
• Registered physical therapist, occupational therapist services required for the treatment of a medical condition and prescribed by a Physician. Allowed Charges do not include services that are primarily educational, sports-related, or preventive, such as, physical conditioning, exercise, or back school.
• Licensed Podiatrist
• Registered nurse
• Services of a certified nurse-midwife for obstetrical care during the pre-natal, delivery and post-partum periods provided the midwife is practicing under the direction and supervision of a Physician.
• Services of a licensed nurse practitioner who is acting within the lawful scope of his/her license provided:
  * The service of the nurse practitioner is in lieu of the service of a Physician, and
  * The nurse practitioner is performing services under the supervision of a licensed Physician, if supervision is required.
• Licensed Physician assistant
• Licensed speech therapist
• Services of a licensed optometrist, but only when providing Medically Necessary medical treatment to the eye that is not covered by the vision plan.
	If Medically Necessary out-patient services are provided from a Non-Contract Provider who is not registered with CMS, the Plan will limit allowed charges to $100 per appointment.
	In-patient services from a Non-Contract Provider not registered with CMS will not be covered.
	If a Medically Necessary service is not available from a Contracted Provider, the Contract Provider Deductible and Percentage Payable will apply to Non-Contract Provider Allowed Charges.
	• Habilitative care is not covered.
	Note: Provided that notice is issued by the Plan to an Eligible Individual, a single medical provider and/or medical facility may be designated as the sole provider of medical services for one or more conditions. Services performed by any other provider or facility other than as named in such notice are not covered.
		Plan Pays
		90%
		
		You Pay
		10%
			Plan Pays
			70%
			
			You Pay
			30%
				Plan Pays
				80%
				
				You Pay
				20%
					Plan Pays
					60%
					
					You Pay
					40%

<u>Physician Visit on-line</u> Beginning 1/1/2017, you can talk to a doctor any time of day, face-to-face on your computer or mobile device by two-way video chat, without an appointment.	Website for on-line doctor visit is: www.livehealthonline.com Other on-line doctor visits are covered not to exceed a Plan benefit payment of $49 per visit.	Plan Pays 100% You Pay 0%	Not Applicable	Plan Pays 100% You Pay 0%	Not Applicable

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Acupuncture Services	Acupuncture services are limited to 20 visits per calendar year.	Plan Pays 90% up to a maximum of $35 per visit You Pay 10% and any amount over the Plan maximum payment of $35	Plan Pays 70% up to a maximum of $35 per visit You Pay 30% and any amount over the Plan maximum payment of $35	Plan Pays 80% up to a maximum of $35 per visit You Pay 20% and any amount over the Plan maximum payment of $35	Plan Pays 60% up to a maximum of $35 per visit You Pay 40% and any amount over the Plan maximum payment of $35
Ambulance Services • Medically Necessary service for ground transportation to or from the nearest Hospital. • A licensed air ambulance to or from the nearest Hospital is also covered at the Allowed Charge if the Fund determines that the location and nature of the Illness or Injury made air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life. • Services provided by an Emergency Medical Technician (EMT) without subsequent emergency transport are paid in accordance with this Ambulance Services benefit	• Expenses for ambulance services are covered only when those services are for an Emergency as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care," or for Medically Necessary inter-facility transport to the nearest Hospital.	Plan Pays 90% You Pay 10%	Plan Pays 90% You Pay 10%	Plan Pays 80% You Pay 20%	Plan Pays 80% You Pay 20%
Outpatient (Ambulatory) Surgery Facility/Center • Ambulatory (Outpatient) Surgical Facility/Center (e.g. surgicenter, same day surgery, outpatient surgery).	• The following maximums payable apply if the surgery is performed in an outpatient Hospital setting instead of an Ambulatory Surgery Center: • $6,000 for arthroscopy • $2,000 for cataract surgery • $1,500 for colonoscopy • $1,000 for endoscopy (on or after January 1, 2017)	Plan Pays 90% You Pay 10%	Plan pays 70% up to a maximum of $300 for the ambulatory surgery facility You pay 30% and any amount over the Plan maximum payment of $300	Plan Pays 80% You Pay 20%	Plan pays 60% up to a maximum of $300 for the ambulatory surgery facility You pay 40% and any amount over the Plan maximum payment of $300

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Chemotherapy	• Some chemotherapy Drugs are only covered by the Specialty Drug Plan and benefits are only available from the Plan's Pharmacy Benefit Manager (PBM) mail order pharmacy.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
Chiropractic Services (for Participant and Spouse only)	• Limited to 20 visits per calendar year. • Chiropractic services are not covered for Dependent Children.	Plan Pays 90% up to a maximum of $25 per visit You Pay 10% and any amount over the Plan maximum payment of $25 per visit	Plan Pays 70% up to a maximum of $25 per visit You Pay 30% and any amount over the Plan maximum payment of $25 per visit	Plan Pays 80% up to a maximum of $25 per visit You Pay 20% and any amount over the Plan maximum payment of $25 per visit	Plan Pays 60% up to a maximum of $25 per visit You Pay 40% and any amount over the Plan maximum payment of $25 per visit
Dental Services Services of a Physician (M.D.) or Dentist (D.D.S.) treating an Injury to natural teeth.	• Services must be received within 6 months following the date of Injury (applied without respect to when the individual was enrolled in the Plan). • Damage to natural teeth due to chewing or biting is not covered under this benefit. • Dental plates, bridges, crowns, caps or other dental prostheses, services, extraction of teeth or treatment to the teeth or gums other than for tumors and accidental injury are not covered.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
Diabetes Instruction Programs	Coverage is available for Diabetes Instruction Programs recognized by the American Diabetes Association.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS

All benefits are subject to the deductible except where noted.

*IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Drugs (Outpatient Medicines) Please refer to the chapter on prescription drugs beginning on page 61.	In-Network Retail Pharmacy (up to a 30-day supply)	PLANS A, B, R AND FLAT RATE			
		Formulary Generic Drug	$10 copay ($15 copay on or after January 1, 2017)		
		Multi-Source Brand Name Drug	$10 plus the difference in cost between the generic and brand name Drugs ($15 copay on or after January 1, 2017)		
		Single Source Formulary Brand Name	$40 copay ($53 copay on or after January 1, 2017)		
		Non-Formulary Drug	$60, provided the Drug has been preauthorized or does not require Utilization Review ($80 copay on or after January 1, 2017)		
		For any new Brand Name Drug approved by the FDA, the copay is 50% of the cost of the drug for a minimum of 24 months after the drug has been approved. If the PBM determines that the new FDA approved drug is a "must not add" drug, the copy will remain at 50% of the cost of the drug.			
		You pay 100% if you use a Non-Network Pharmacy unless there are no Network pharmacies available within 10 miles. The Plan will not reimburse any more than it would have had you used an in-Network pharmacy			
	Mail Order Services (up to a 90-day supply)	Formulary Generic Drug	$20 copay ($26 copay on or after January 1, 2017)		
		Multi-Source Brand Name Drug	$20 plus the difference in cost between the generic and brand name Drugs ($26 copay on or after January 1, 2017)		
		Single Source Formulary Brand Name	$80 copay ($106 copay on or after January 1, 2017)		
		Non-Formulary Drug	$100, provided the Drug has been preauthorized or does not require Utilization Review ($133 copay on or after January 1, 2017)		
	Specialty Drugs (up to a 30-day supply)	Formulary Generic Drug	$10 copay		
		Multi-Source Brand Name Drug	$20 plus the difference in cost between the generic and brand name Drugs ($26 on or after January 1, 2017)		
		Single Source Formulary Brand Name	$40 copay ($53 copay on or after January 1, 2017)		
		Non-Formulary Drug	$60 provided the Drug has been preauthorized or does not require Utilization Review ($80 copay on or after January 1, 2017)		
		For any new Brand Name Drug approved by the FDA (including injectable and infusion drugs), the copay is 50% of the cost of the drug for a minimum of 24 months after the drug has been approved. If the PBM determines that the new FDA approved drug is a "must not add" drug, the copy will remain at 50% of the cost of the drug.			
	If the cost of the drug is less than the copay, you pay just the drug cost. Specialty Drugs must be obtained from the Pharmacy Benefit Manager or no Plan benefit is available.				

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
<u>Medical Equipment and Supplies</u> Benefits are payable only if the equipment or supply is: • Ordered by a Physician; • Of no further use after the medical need ends; • Usable only by the patient; • Not primarily for the comfort or hygiene of the patient; • Not for environmental control; • Not for exercise; • Manufactured specifically for medical use; • Approved as effective and usual and customary treatment of a condition as determined by the Fund; and • Not for prevention purposes. Coverage is provided for Medically Necessary nondurable supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual. Coverage is provided for up to a 31-day supply of Medically Necessary nondurable supplies for home/personal use: • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. • Dialysis supplies. • Diabetic supplies. • Colostomy and ostomy supplies.	• Rental charges are covered if they do not exceed the reasonable purchase price of the equipment. • Orthopedic shoes are covered only if they are joined to a brace. • Custom-made orthotics are covered. • Medical appliances, devices, bandages, braces, splints and other supplies or equipment are not covered, except for diabetic supplies. • Supplies that have use when the medical condition ends are not covered under the Nondurable Medical Supply benefit.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
<u>Family Planning, Reproductive, Contraceptive, Fertility Services</u> Covered Services include: • Sterilization services (e.g., vasectomy, tubal ligation). • Contraception-related services including services in connection with obtaining or removing a prescription contraceptive device or implant. • Prescription contraceptives.	No coverage is available for reversal of sterilization procedures, infertility treatment along with services to induce pregnancy.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
<u>Hearing Aid Benefit</u>	No benefits will be provided for: • A hearing examination without a hearing aid being obtained; • The replacement of a hearing aid for any reason more often than once during any 3-year period; • Batteries or any other ancillary equipment other than that obtained upon the purchase of the hearing aid; or • Expenses incurred for which the individual is not required to pay.	100% up to a maximum payment of $800 per ear (in any 3-year period), not to exceed Covered Expenses, for the examination, hearing aid and all repairs or servicing. Not subject to Deductible or Coinsurance Maximum.		80% up to a maximum payment of $800 per ear (in any 3-year period), not to exceed Covered Expenses, for the examination, hearing aid and all repairs or servicing. Not subject to Deductible or Coinsurance Maximum.	

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
<u>Home Health Care and Home Infusion Therapy Services</u> Covered Expenses include: • Services of a registered nurse. • Services of a licensed therapist for physical therapy, occupational therapy and speech therapy. • Services of a medical social worker. • Services of a health aid who is employed by (or contracted with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as a professional coordinator. • Necessary medical supplies provided by the Home Health Agency.	Please note: • The patient must be confined at home under the active medical supervision of a Physician ordering home health care and treating the Illness or Injury for which that care is needed. • Services must be provided and billed by the Home Health Agency. • Services must be consistent with the Illness, Injury, degree of disability and medical needs of the Patient. • Benefits are provided only for the number of days required to treat the Eligible Individual's Illness or Injury. • Injectable and infusion Drugs are not covered under this Home Health Care benefit. Please see the Drug section of this Schedule of Medical Benefits for other drug coverage.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
<u>Hospice</u> • Hospice services include inpatient hospice care and outpatient home hospice when the patient has an Illness for which the prognosis for life expectancy is estimated to be 6 months or less, as certified by the Physician. The Patient must be formally admitted to an Approved Hospice Program, and the attending Physician must approve the patient's written treatment program. • Approved Hospice Program. An Approved Hospice Program must meet State licensure requirements as a Hospice (in states with licensure requirements) and be a Medicare-certified hospice, or a Medicare demonstration hospice site, or accredited by The Joint Commission (TJC). The Hospice must notify the Fund of a Patient's admission into a Hospice program and submit a written treatment plan to the Fund.	Covered Hospice care services include the following: • professional nursing visits • medical social services • home health aide services • nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation. • medical supplies • bereavement services (limited to 8 visits within one year of Patient's death, not to exceed $25 per visit), and respite care (limited to 8 days The Hospice benefit does not cover: • medical transportation, food, clothes or housing • volunteer services • financial or legal counselors • services provided by household members or family and friends	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Laboratory Services (Outpatient) • Technical and professional fees.	• Services must be ordered by a Physician, including laboratory tests associated with diagnosing a viral illness. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
Maternity Services • Hospital and Birth (Birthing) Center charges and Physician fees for Medically Necessary maternity services for all covered females. Coverage for the baby is only payable if the child is a Dependent Child as defined in this Plan, and properly enrolled. • Prenatal vitamins containing fluoride or folic acid are covered. • See the Eligibility chapter on how to enroll a Newborn Dependent Child(ren).	• Routine newborn nursery charges billed by a Non-Contract Hospital are NOT covered. • Hospital Length of Stay for Childbirth: For information on Utilization Review for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Anthem to pre-authorize the extended stay.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
Member Assistance Program (MAP) • Member Assistance Program (MAP) Services: This plan offers up to 4 free MAP visits per incident, per household member at no cost to you. The phone number for the MAP program is listed on the Quick Reference Chart in the front of this document.	• Face-to-Face counseling • Legal Assistance • Financial Assistance • Identification Recovery • Tobacco Cessation • Dependent Care and Daily Living Resources	Plan Pays 100% for face-to-face counseling You pay 0%	Not Covered	Plan Pays 100% for face-to-face counseling You pay 0%	Not Covered

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
<u>Mental Health</u> • Inpatient hospitalization, residential treatment and partial day care. • Outpatient visits.	Prescription drugs for mental health are payable under the Drug section in this Schedule of Medical Benefits. If Medically Necessary out-patient services are provided from a Non-Contract Provider who is not registered with CMS, the Plan will limit allowed charges to $100 per appointment. In-patient services from a Non-Contract Provider not registered with CMS will not be covered.	Mental Health outpatient visits Plan pays 100% (does not include care in outpatient facilities) Mental Health inpatient Plan pays 90% You pay 10% Emergency Room treatment Plan pays 100% All other Plan pays 90% You pay 10%	Emergency Room treatment Plan pays 100% All other Plan pays 70% You pay 30%	Mental Health outpatient visits Plan pays 100% (does not include care in outpatient facilities) Mental Health inpatient: Plan pays 90% You pay 10% Emergency Room treatment Plan pays 100% All other Plan pays 80% You pay 20%	Emergency Room treatment Plan pays 100% All other Plan pays 60% You pay 40%
<u>Prosthetic Devices</u>	• Coverage is available for artificial limbs and/or eyes.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%

<u>Radiology (X-Ray), Imaging Studies and Radiation Therapy Services (Outpatient)</u>
• Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry.
	• Covered only when ordered by a Physician or Health Care Practitioner.
	• For the following outpatient diagnostic imaging services, a Physician must obtain Utilization Review from the Review Organization:
	  • CT/CTA
	  • MR/MRI
	  • Nuclear cardiology
	  • PET scan
	  • Echocardiography
		Plan Pays
		90%
		
		You Pay
		10%
			Plan Pays
			70%
			
			You Pay
			30%
				Plan Pays
				80%
				
				You Pay
				20%
					Plan Pays
					60%
					
					You Pay
					40%

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
<u>Reconstructive Services and Breast Reconstruction After Mastectomy</u> This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that requires any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including: • reconstruction of the breast on which the mastectomy was performed; • surgery and reconstruction of the other breast to produce a symmetrical appearance; and • prostheses and physical complications for all stages of mastectomy, including lymphedemas.	• Reconstructive Surgery is covered only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital or developmental anomaly that causes a functional defect.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Skilled Nursing Facility (SNF) including Rehabilitation Services • Skilled Nursing Facility (SNF). • Services of a licensed therapist for physical therapy or occupational therapy. • Services of a licensed speech therapist only for speech therapy that is provided to an Eligible Individual who had normal speech at one time and lost it due to an Illness or Injury.	• Benefits will be paid for Skilled Nursing Facility and Home Health Care as an alternative to Hospital care when the care is arranged by the attending Physician. • A maximum of 70 days of Skilled Nursing Facility care will be covered during any Period of Confinement. A new Period of Confinement will begin after 90 days have passed since the end of the last confinement in a Skilled Nursing Facility. • Inpatient Rehabilitation admission requires Utilization Review by calling Anthem. • Physical therapy services that are primarily educational, sports related or preventive, such as physical conditioning, exercise or back school are not covered. • Habilitative services are not covered. This includes any physical therapy, occupational therapy, and/or speech therapy provided to individuals with developmental delays that have never acquired normal functional abilities.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
Substance Abuse Treatment • Inpatient hospitalization, residential treatment and partial day care. • Outpatient visits	Prescription drugs for substance abuse are payable under Drugs in this Schedule of Medical Benefits. If Medically Necessary out-patient services are provided from a Non-Contract Provider who is not registered with CMS, the Plan will limit allowed charges to $100 per appointment. In-patient services from a Non-Contract Provider not registered with CMS will not be covered.	Chemical Dependency (inpatient and outpatient) Plan pays 100% Emergency Room treatment Plan pays 100% All other Plan pays 90% You pay 10%	Emergency Room treatment Plan pays 100% All other Plan pays 70% You pay 30%	Chemical Dependency (inpatient and outpatient) Plan pays 100% Emergency Room treatment Plan pays 100% All other Plan pays 80% You pay 20%	Emergency Room treatment Plan pays 100% All other Plan pays 60% You pay 40%

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers
Transplants (Organ and Tissue) • Organ and tissue transplants: Allowed Charges incurred by the donor and the recipient when the recipient is an Eligible Individual. Allowed Charges may include patient screening, organ procurement and transportation of organ or tissue, surgery and Hospital charges for the recipient and donor, follow-up care in home or Hospital, and immunosuppressant drugs. • Benefits payable for an organ donor who is not an Eligible Individual will be reduced by any amounts paid or payable by that donor's own health coverage.	• No benefits are available without Utilization Review from Anthem. • In no case will the Plan cover expenses for transportation of the donor, surgeons or family members. The following criteria must be met for any transplant benefits to be payable: • The transplantation procedure is not considered an Experimental or Investigative Procedure as defined in the definition section of this document. • The Patient is admitted to a transplantation center program in a major medical center approved either by the federal government or the appropriate state agency of the state in which the center is located; and • The recipient of the organ or tissue is an Eligible Individual covered under the Plan.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%
Wellness (Preventive) Program Well Child Examinations and Immunizations Normal Plan benefits including Deductible and Coinsurance apply to all covered preventive services.	• The Plan will cover: • Routine physical examinations for Dependent children younger than age 19 (limited to one physical exam in any 12-month period for after age 2). • Routine immunizations that are provided in accordance with the guidelines recommended by the American Academy of Pediatrics. • For newborn children, the benefit includes Physician visits in the Hospital and Physician standby charges for cesarean section, but not well-baby Hospital nursery charges at a Non-Contract Hospital.	Plan Pays 90% You Pay 10%	Plan Pays 70% You Pay 30%	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%

SCHEDULE OF INDEMNITY MEDICAL PLAN BENEFITS All benefits are subject to the deductible except where noted. *IMPORTANT: Non-Contract providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.					
Benefit Description	Explanations and Limitations	PLANS A/R		PLANS B/FLAT RATE	
		Contract Providers	Non-Contract Providers	Contract Providers	Non-Contract Providers

<u>Wellness (Preventive) Program for Participant and Spouse</u>
 	
Normal Plan benefits including Deductible and Coinsurance apply to all covered preventive services.
	The Plan will cover:
	• A routine physical examination for a Participant and Spouse once within a 12-month period.
	• Prostate Specific Antigen (PSA) test for males age 50 and over.
	• A colonoscopy* and sigmoidoscopy examination if your Physician considers you at high risk for colon cancer.
	• A routine mammogram, including a digital mammogram, obtained as a diagnostic screening procedure. Benefits will be paid in accordance with the following frequency schedule:
	  • For women age 35 through 39 – one baseline mammogram
	  • For women ages 40 and over – one mammogram every year
	
	* Refer to "Hospital Surgical Services (Outpatient)" and "Outpatient (Ambulatory) Surgery Facility/Center" section of this Schedule of Indemnity Medical Plan benefits.
		Plan Pays
		90%
		
		You Pay
		10%
			Plan Pays
			70%
			
			You Pay
			30%
				Plan Pays
				80%
				
				You Pay
				20%
					Plan Pays
					60%
					
					You Pay
					40%

UTILIZATION REVIEW PROGRAM

Purpose of the Utilization Review Program

The Plan's Utilization Review Program is designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Review Program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, you may be responsible for paying more out of your own pocket.

Management of the Utilization Review Program

The Plan's Utilization Review Program is administered by Anthem. In addition, certain outpatient drugs may require Utilization Review as managed by the Pharmacy Benefit Manager, Express Scripts.

Elements of the Utilization Review Program: The Plan's Utilization Review Program consists of:

1. **Pre-authorization (preservice) review**: review of proposed health care services before the services are provided;
2. **Concurrent (continued stay) review**: ongoing assessment of the health care as it is being provided, typically involving inpatient confinement in a hospital or health care facility or review of the continued duration of healthcare services;
3. **Retrospective review**: review of health care services after they have been provided.

Restrictions and Limitations of the Utilization Review Program

1. The fact that your Physician recommends a surgery, hospitalization, or that your Physician proposes or provides medical services or supplies doesn't mean that the services or supplies will be an Allowed Charge or be considered Medically Necessary for determining coverage under the Medical Plan.
2. All treatment decisions rest with you and your Physician. You should follow whatever course of treatment you and your Physician (or other provider) believes to be the most appropriate, even if Anthem does not certify proposed surgery/treatment/service or admission as Medically Necessary.
3. **Precertification of a service does not guarantee that the Plan will pay benefits for that service** because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during precertification varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

How Utilization Review Works

Utilization Review is a procedure, administered by Anthem, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary. **The following services must be approved:**

SITUATION	PLAN REQUIREMENTS FOR UTILIZATION REVIEW
Non-emergency admission to a Hospital (including Mental Illness or Chemical Dependency treatment)	Anthem must approve the Hospital stay before admission (except for a normal vaginal delivery less than 48 hours or a C-section less than 96 hours). If you use a Contract Hospital, the Hospital will handle this for you. If you use a Non-Contract Hospital, you are responsible for seeing that your Physician obtains Utilization Review for you. You are not required to obtain Utilization Review for a hospitalization when the Plan is the secondary payer of benefits.
Hospitalization as a result of a medical emergency	If you are admitted to a Non-Contract Hospital, you, your Physician or someone acting on your behalf must contact Anthem for certification within 24 hours of admission.

SITUATION	PLAN REQUIREMENTS FOR UTILIZATION REVIEW
Admission for childbirth	You do not need Utilization Review for a hospital stay for mother and newborn of less than 48 hours following a normal delivery or a stay of less than 96 hours following a cesarean section
Organ or tissue transplant	All planned services must be approved by Anthem before services begin.
Certain Outpatient diagnostic imaging services	CT/CTA, MR/MRI, Nuclear cardiology, PET scan and echocardiography before the service is provided.
Receiving Utilization Review does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.	

Anthem will determine whether a proposed admission to the Hospital is Medically Necessary and if so, how many days will be covered. Anthem and the Physician will review the facts about Patient's case to determine if hospitalization is necessary or if effective treatment can be given in a less intensive setting such as outpatient care. Once you are admitted, Anthem monitors the Hospital stay and if additional days are required because of complications or other medical reasons, your stay will be approved for the appropriate number of additional inpatient days. This is called Concurrent Review.

- A Contract Hospital will take care of the Utilization Review process for you (including concurrent review).
- If you are admitted to a Non-Contract Hospital, it will be your responsibility to make sure your Physician contacts Anthem for Utilization Review. For Emergency admission, Anthem must be notified within 24 hours after you are admitted. Anthem will determine the number of days of confinement that are Medically Necessary.
- If you are admitted to a Non-Contract Hospital that does not participate in a concurrent review program, your Hospital stay will be reviewed after you leave the Hospital. If Anthem finds that any portion of your stay was not Medically Necessary, no benefits will be payable for Hospital and Physician charges incurred during the portion of the Hospital stay that was determined to be not Medically Necessary.
- Benefits will be paid for an organ or tissue transplant **only** if the medical services are approved in advance and managed by Anthem.

Failure to comply with the Plan's requirements for Utilization Review and notification of an emergency admission will result in a reduction in benefits and increase your out-of-pocket costs.

Hospital Length of Stay for Childbirth

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician, after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Utilization Review.

Emergency Hospitalization: If an emergency requires hospitalization, there may be no time to contact Anthem before you are admitted. If this happens, Anthem must be notified of the hospital admission within 24 hours. You, your Physician, the hospital, a family member or friend can make that phone call to Anthem. This will enable Anthem to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Physician or other providers of the various Contracted support providers and benefits available for you and offer recommendations, options and alternatives for your continued medical care.

Retrospective (Post-Service) Review

Claims for medical services or supplies that have not been reviewed under the Plan's Utilization Review program (including Pre-authorization, Concurrent (Continued Stay) Review) may, at the option of the Trust Fund Office, be subject to retrospective review to determine if they are Medically Necessary. If the Trust Fund Office receives a determination from the Utilization Review company that services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies.**

Appealing a Utilization Review Determination (Appeals Process)

You may request an appeal of any adverse review decision made during the Utilization Review process described in this chapter. To appeal a denied claim/bill, see the Claim Filing and Appeal Information chapter of this document.

MEDICAL PLAN EXCLUSIONS

General Exclusions (applicable to all medical services and supplies)

No benefits are payable for the following:

1. Any amounts in excess of Allowed Charges for Non-Contract Providers or the contract rate for Contract Providers.
2. Expenses for which benefits are payable under any other programs provided by the Fund.
3. Any expense incurred for services or supplies furnished prior to the date you or your Dependents became eligible. An expense is considered incurred on the date the person receives the service for which the charge is made.
4. Any expense incurred after eligibility terminates, except as provided under the "Extended Benefits for Disability" provision.
5. Custodial Care or rest cures, any care in a home for the aged, nursing, convalescent, or rest home, or institution of a similar character, except as provided by the Skilled Nursing Facility benefit.
6. Services received while an Eligible Individual is confined in a Hospital operated by the United States Government or an agency of the United States Government except that the Plan, to the extent required by law, will reimburse a VA Hospital for care of a non-service-related disability if the Plan would normally cover the care if the Department of Veterans Affairs were not involved.
7. Any work-related Injury or Illness. However, the Plan will pay benefits on behalf of an Eligible Individual who has incurred an occupational Injury or Illness subject to the following conditions:
    a. The Eligible Individual provides proof of denial of a Workers' Compensation claim and signs an agreement to diligently prosecute his/her claim for Workers' Compensation benefits or for any other available occupational compensation benefits; and
    b. The Eligible Individual agrees to reimburse the Fund for any benefits paid by the Fund by consenting to a lien against any occupational compensation benefits received through adjudication, settlement or otherwise; and
    c. The Eligible Individual cooperates with the Fund or its designated representative by taking reasonably necessary steps to obtain reimbursement, through legal action or otherwise, for any benefits paid for the Eligible Individual's occupational Injury or Illness.
8. Conditions resulting from act of war or armed invasion.
9. Treatment on or to the teeth, or gums (other than for tumors), except as provided for dental injury; extraction of teeth; treatment of dental abscess or granuloma, dental plates, bridges, crowns, caps or other dental prosthesis.
10. Eyeglasses, contact lenses, routine eye examinations, eye refractions for the fitting of glasses, vision therapy (orthoptics), or any refractive eye surgery.
11. Routine newborn nursery charges billed by a Non-Contract Hospital.
12. Cosmetic services, except for conditions resulting from an accident or a functional disorder or reconstructive surgery following a mastectomy.
13. Any expense incurred for services or supplies that constitute personal comfort or beautification items, or for weight loss programs.
14. Drugs, except while the Patient is hospitalized and entitled to receive Hospital benefits (see also information on prescription drug benefits for individuals enrolled in the Indemnity Medical Plan).
15. Hospital admissions primarily for custodial care.
16. Services of a naturopath or any other provider not meeting the definition of Physician, except as may be provided under specific benefits of the Plan.
17. Services not specifically listed as covered services, or those services that are not Medically Necessary or not considered as standard medical practice by the Plan.

In general, services that are not Medically Necessary are not covered by the Plan.

18. Services for which the Eligible Individual is not legally obligated to pay or for which no charge is made to the Eligible Individual. Services for which no charge is made to the Eligible Individual in the absence of insurance coverage, except services received at a non-government charitable research hospital.
19. Professional services received from a registered nurse or physical therapist who lives in the Eligible Individual's home or who is related to the Eligible Individual by blood or marriage.
20. Inpatient Hospital charges in connection with a Hospital stay primarily for physical therapy.
21. Educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
22. Orthopedic shoes (except when joined to braces) or shoe inserts (except custom-made orthotics), air purifiers, air conditioners, humidifiers, exercise equipment for conditioning (e.g., Nautilus Equipment, etc.), or supplies for comfort, hygiene or beautification.
23. Educational services, nutritional counseling or food supplements except for benefits provided for Diabetic Instruction programs.
24. Physical therapy services that are primarily educational, sports-related or preventive, such as physical conditioning, exercise or back school.
25. Speech therapy, occupational therapy (except rehabilitation treatment following an Illness or Injury). Speech therapy is covered only for an Eligible Individual who had normal speech at one time and lost it due to Illness or Injury.
26. Infertility treatment along with services to induce pregnancy and complications resulting from those services, including, but not limited to: services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen or other fees, cryostorage of egg/sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization.
27. Hypnotism, biofeedback, stress management, and any goal-oriented behavior modification, such as to quit smoking or lose weight, or to control pain.
28. Services primarily for weight loss.
29. Claims submitted more than 12 months from the date of service.
30. Any services and supplies in connection with Experimental or Investigational Procedures as defined in the Definitions section of this document.
31. Reimbursement for percentage of the amount that would have been payable in accordance with Medicare allowable payments for expenses from Non-Contract Hospital, Non-Contract Facility and other Non-Contract providers who did not complete enrollment in the Medicare program or did not submit an affidavit to Medicare expressing their decision to opt-out of the Medicare program.
32. Habilitative services are not covered. This includes any physical therapy, occupational therapy, and/or speech therapy provided to individuals with developmental delays that have never acquired normal functional abilities.

PRESCRIPTION DRUG BENEFITS

The prescription drug benefits described below are only for Participants and Eligible Dependents who are enrolled in the Indemnity Medical Plan. These benefits do not apply to Kaiser members.

The Prescription Drug Plan is managed by the Fund's Pharmacy Benefit Manager (PBM). The PBM uses a variety of tools to provide safe access to approved prescription drugs. In addition to an approved list of drugs, known as a formulary, the PBM employs other edits which may include, but not be limited to: Prior Authorization for certain therapies, step therapy edits that require the use of tried and proven prescription drugs prior to the approval of newer more costly drugs, frequency and dosing limits, retail refill allowance that channels participants into the mail order delivery method, and Genetic and/or Efficacy testing. Prescriptions submitted that do not comply with PBM rules will be denied. Additionally, the PBM actively monitors for fraud, waste, and abuse which does occur, and intervenes to case manage such events.

Express Scripts is the PBM that administers the prescription drug program. It provides a network of participating retail pharmacies, mail order services and specialty pharmacy programs.

The Plan provides a retail pharmacy program and a mail order option for your prescription drug needs. When you need a medication for a short time – an antibiotic, for example – it is best to choose the retail pharmacy program. If you are taking a medication on a long-term basis, it is usually less costly and more convenient to have it filled through the mail order program.

Generic Versus Brand Name Medications

Many prescription Drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity and effectiveness. However, on average, generic medications can save about half the cost of brand name medications, and for some medications this savings can be even greater. Choosing generic medications can be a significant source of savings for both you and the Trust Fund. You may want to ask your Doctor or pharmacist if a generic equivalent is available for the prescriptions you need filled.

To encourage you to use generic medications whenever possible, your Copayments will be lower when you use generic medications.

Brand name Proton Pump Inhibitors (PPI) and Cholesterol lowering drugs are only covered if you receive prior approval. Effective January 1, 2017, combination PPI medications are not covered under the Plan.

Single Pharmacy as the Sole Provider

Provided that prior notice is issued by the Plan, a single pharmacy may be designated as the sole provider to dispense one or more prescription drug class(es) to a Participant and/or Dependent (medications from other pharmacies will be excluded).

No Deductible and No Out-of-Pocket Limits

You do not have to meet a deductible before the Plan starts paying prescription Drug benefits; instead you will pay a Copayment for each prescription. The prescription Drug benefits are separate from Indemnity Medical Plan benefits, so amounts you pay for prescription Drugs do not count toward the medical plan's Deductible or Out-of-Pocket Limits. Please refer to the Schedule of Benefits on page beginning on page 37 for a description of your prescription drug Copays.

Retail Pharmacy Program

The Plan will provide up to a 30-day supply of medication per prescription through the retail pharmacy program. If you need to take maintenance medications on an ongoing basis, you can receive up to a 90-day supply through the mail order program.

When you are eligible for coverage, you will receive a Prescription Drug ID card. If you live within 10 miles of a network pharmacy, you must use a network pharmacy to have retail pharmacy benefits. When you have a prescription filled at a retail network pharmacy:

- Show the pharmacist your ID card; and
- Pay your Copayment for the prescription (the pharmacy bills the Plan the remaining amount).

Finding a Network Pharmacy. Most of the retail pharmacy chains are in the pharmacy network. To find a pharmacy near you, call Express Scripts at (800) 939-7093, ask the pharmacy if it participates in the Express Scripts network, or go to www.express-scripts.com

The pharmacist will automatically fill your prescription with a generic Drug if available unless you or your doctor specifies otherwise.

- The **"formulary"** is the list of preferred Drugs established by Express Script's independent pharmacy & therapeutics committee. The committee reviews Drugs on the preferred list based on safety, efficacy and cost.
- **"Multi-source"** is a brand name Drug that has a generic equivalent.
- **"Single-source"** is a brand name Drug that does not have a generic equivalent.

Note: The formulary includes at least one Drug choice, and in most cases multiple Drug choices, for each therapeutic category.

If There is No Network Pharmacy in Your Area

The Plan will reimburse you for covered prescriptions filled at a non-network pharmacy **only if you live more than 10 miles from the closest network pharmacy**. Your pharmacist must complete a prescription Drug claim form, which is available from the Trust Fund Office. Covered Drugs will be reimbursed at 100% of the reasonable cost less the applicable Copayment and any other amount due from you, as shown above.

Note. If you fail to show your Prescription Drug ID card to the network pharmacist, you must pay the pharmacy the full price for the prescription. You may then send a claim form to Express Scripts for reimbursement. Express Scripts will reimburse you based on the amount the Fund would have paid if your prescription were filled at a network pharmacy and you will be responsible for any remaining charges.

Mail Order Program

You can save money by using the mail order program for your maintenance medications. Maintenance medications are prescription Drugs that are used on an ongoing basis. When you use the mail order program, you can have prescriptions filled for up to a 90-day supply. Your prescription will be filled with a generic Drug if available unless your doctor indicates no substitution may be made. To use the mail order program:

- Ask your doctor for a prescription for up to a 90-day supply, with refills if appropriate.
- Mail the original prescription along with the prescription order form and your payment or credit card information to Express Scripts using the special pre-addressed envelope. You may also have your doctor fax your prescriptions. Ask your doctor to call Express Scripts at (800) 473-3455 for faxing instructions.

Refer to the separate Express Scripts Prescription Drug Handbook for more detailed information on how to use the Express Scripts mail order program and Specialty Care Pharmacy. This handbook is available from the Trust Fund Office.

If you need to begin taking the medication right away, you may want to ask your doctor for two prescriptions: a short-term supply that you can have filled immediately at a network retail pharmacy; and a refillable supply that you can have filled through the mail order program.

You must use the Mail order program if you obtained 2 prescriptions for maintenance medications at a Retail Pharmacy. If you do not, there are no benefits available.

Required Utilization Review

Certain drugs require Utilization Review by Express Scripts. In most cases, you will need to take the formulary Drug before a non-formulary Drug will be approved for coverage. To request Utilization Review of a drug, your Physician should call Express Scripts at (800) 939-7093.

Requests for required Utilization Review are considered "pre-service claims." If you disagree with the decision made on your Physician's request for Utilization Review, you may appeal it. See the information on pre-service claims in the "Claims and Appeals Procedures" section of this booklet.

Off label use of drugs (for an indication other than described in the FDA approved drug label) will be allowed if prior approval is first obtained from the PBM.

Utilization Review does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.

For a list of drugs that require Utilization Review, call Express Scripts at (800) 939-7093, or use the interactive look-up tool at www.express-scripts.com. If you're a first-time user of the website, you will need to register – have your participant ID and a prescription number available.

Specialty Care Pharmacy

Complex conditions, such as anemia, hepatitis C, multiple sclerosis, asthma and rheumatoid arthritis, are treated with specialty medications. Specialty medications are typically injectable Drugs administered by you or a healthcare professional, and they often require special handling. Specialty medications are provided by Express Scripts' specialty care pharmacy – ***Accredo Health Group.***

If you use specialty medications, the Express Scripts specialty care pharmacy offers the following extra services:

- Answers to your questions or concerns about your specialty medications from a pharmacist 24 hours a day, 7 days a week.
- Coordination of home care and other healthcare services, when appropriate.
- Expedited delivery of your medications at no extra charge.

Any required Utilization Review will be handled for you when you or your doctor call the Express Scripts Specialty Care Pharmacy.

Note: Specialty medications are available only from the PBMs Mail Order Pharmacy except that certain emergency drugs may be provided by a retail Network pharmacy (such as the low molecular weight heparin products that are used for blood clots after hip replacement surgeries).

Limitations on Specialty Drugs

- Specialty Drugs are covered only if they are obtained from the Express Scripts specialty care pharmacy. These Drugs will not be available from a retail network pharmacy and will not be covered by the Indemnity Medical Plan.
- Benefits for specialty medications not obtained from Express Scripts' specialty care pharmacy will be limited to what the Fund would have paid if the Drug had been obtained through Express Scripts, and you will be responsible for any remaining charges. This could leave you with significant out-of-pocket expenses.

Covered Prescription Drugs

- Drugs requiring a written prescription from a licensed Physician or Dentist and prescribed for treatment of an Illness or Injury, including new prescription Drugs approved by the federal Food and Drug Administration
- Insulin and Medically Necessary diabetic supplies. Pen products for insulin administration (except for pre-filled syringes) are covered in the following circumstances only and subject to prior authorization by Express Scripts:
    - If you are visually impaired or have some physical impairment that prevents you from using an insulin vial and syringe
    - If you need an intensive insulin regimen that requires you to inject insulin at least three times per day and monitor your blood sugar at least twice a day

- If you are a Dependent under age 19
- If you are the Participant and you need to inject at work

- Injectable and infusion (IV) Drugs administered on an outpatient basis, subject to the following requirements:
  - The Drug must be prescribed by a Physician for self-injection by you or for administration by a health care professional in an infusion clinic, outpatient department of a Hospital, Physician's office or in your home
  - The Drug must be provided by the Express Scripts specialty care pharmacy. These medications will not be provided by a retail network pharmacy, except for the following Drugs when needed in an Emergency situation: low molecular weight heparin products that are used for blood clots and after hip replacement surgery
  - Plan benefits for injectable or infusion Drugs not obtained from the Express Scripts specialty care pharmacy will be limited to the amount the Fund would have paid if the Drug had been obtained through Express Scripts.

See "Specialty Care Pharmacy – Injectable and Infusion Drugs" above for more information.

- Prescription contraceptives
- Prenatal vitamins containing fluoride or folic acid

Prescription Drugs Not Covered

1. Compounded dermatological preparations such as ointments and lotions that must be prepared by a pharmacist according to a Physician's prescription are not covered
2. Prescription Drugs purchased at a non-network pharmacy unless you live more than 10 miles from a network pharmacy
3. Medications prescribed for cosmetic purposes only
4. Over-the-counter medications that do not require a Physician's written prescription by state or federal law and any prescription medication that has an over-the-counter equivalent medication
5. Medications for smoking cessation; appetite suppressants or other weight loss drugs or dietary supplements
6. Medications with no approved federal Food and Drug Administration indications (e.g., no approved indications by the FDA that the Drug is effective for a specific course of treatment)
7. Medical appliances, devices, bandages, braces, splints and other supplies or equipment, except for diabetic supplies
8. Drugs not necessary for the care or treatment of bodily Illness or Injury; medications used for experimental indications, and/or dosage regimens determined to be Experimental or Investigational
9. Drugs that are provided by or paid for by any governmental program, national, state, county or municipal
10. Prescription vitamins (except the pre-natal vitamins mentioned above)
11. Fertility Drugs
12. Immunization agents
13. Sexual dysfunction drugs are limited in the quantity covered; contact Express Scripts for information on the limits. Injectable sexual dysfunction drugs are not covered.
14. Prescription refills dispensed after one year from original date of dispensing
15. Drugs administered in Hospitals, clinics or similar institutions or in a doctor's office (except for medications obtained from the Express Scripts specialty care pharmacy)
16. Charges for prescription Drugs purchased from a retail pharmacy that contain more than a 30-day supply per prescription
17. Replacement prescriptions due to loss, theft or breakage

Claims

You will need to send a claim for reimbursement to Express Scripts if you live more than 10 miles from the nearest network pharmacy and have your prescription filled at a non-network pharmacy or if you forget your identification card and have to pay full price at a network pharmacy. You may also send a coordination of benefits claim for reimbursement of copayments charged by another prescription plan when this Plan is secondary.

You can print a claim form from the Carpenters website (carpenterfunds.com) or call Express Scripts customer service.

The address is:

Express Scripts
P.O. Box 14711
Lexington, Kentucky 40512

Appeals for Denied Prescription Drug Benefits

Prescription Drug benefits will be paid in accordance with the terms of the Plan. If you dispute any denial of benefits or the amount of any payments, you may appeal the decision. See "Claims and Appeals Procedures" in this booklet for more information.

Note About Medicare Prescription Drug Coverage

The Trust Fund has determined that the prescription drug coverage under this Plan is "creditable" for purposes of Medicare Part D. "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

If you are eligible for Medicare and will soon retire, see the Fund's Notice of Creditable Coverage (a copy is available from the Trust Fund Office) for more information about creditable coverage or Medicare Part D coverage. See also: www.medicare.gov for personalized help or call (800) 633-4227.

VISION PLAN COVERAGE

These benefits are available to Participants who are enrolled in the Indemnity Medical Plan. Kaiser Participants have their vision benefits through Kaiser HMO.

The Fund contracts with Vision Service Plan (VSP) and its network of vision care providers to provide covered vision services at contract prices. If you select a doctor from the VSP network of providers and do not order optional items, the Plan provides exams and eyeglasses at no expense to you, except for the Copayments shown below.

Costco Wholesale stores are contract providers who receive the maximum Plan benefits available.

How the Plan Works

Steps for using a VSP Member Doctor are as follows:

- Call any VSP doctor to make an appointment. Identify yourself as a VSP member and provide your social security number and the name of the group plan ("Carpenters Health and Welfare Trust Fund for California").
- After you have scheduled an appointment, the VSP Member Doctor will contact VSP to verify your eligibility and Plan coverage. The doctor will also obtain authorization from VSP for services and materials.
- When you go for your visit, pay the VSP Member Doctor your $10 exam Copayment and $25 for materials, if applicable. VSP will pay the doctor directly for the balance of the covered charges. Any additional services or materials not covered by the Plan may be arranged between you and the Doctor, and the cost for those services or materials will be your responsibility.
- If you qualify for the low vision benefit, you will have to pay your share of the charge for supplemental aids and any amount over the plan maximum.

To find a VSP provider, call VSP at (800) 877-7195 or go to the VSP website at www.vsp.com and use the "Find a doctor" feature.

When you use a VSP Member Doctor, you are responsible for payment of the Copayment(s) and any amounts for optional or non-covered items as well as any overages on materials; you do not need to file a claim for reimbursement. However, if you use a non-VSP provider, you must pay for all services and supplies at the time you receive them and then submit a claim for reimbursement. You will be reimbursed the appropriate amount shown in the Non-Member Provider Schedule of Allowances after deduction of your Copayment(s).

See "How to File a Claim" at the end of this section for information on submitting claims for non-VSP provider services.

Copayments/Schedule of Benefits

You pay the Copayment regardless of whether you use a VSP Member Doctor or a non-VSP provider. The $10 exam Copayment is due only once each year, for the first service you receive each year (unless you qualify for the low vision benefit, which has additional Copayments).

Vision Benefits	VSP Member Doctor	Non-VSP Provider
Copayments		
Exam	$10	$10
Materials (Prescription and safety Glasses)	$25	$25
Vision Examination – Limited to once every 12 months	Plan pays 100%, up to network provider contract rates	Plan pays up to $40
Lenses – Limited to once every 12 months	Plan pays 100%, up to network provider contract rates	Plan pays up to:
Single Vision		$40
Lined Bifocal		$60
Lined Trifocal		$80
Lenticular		$100
Tints		$ 5

Vision Benefits	VSP Member Doctor	Non-VSP Provider
Frames – Limited to once every 24 months	Effective January 1, 2017, up to $150 retail allowance. Prior to January 1, 2017, up to $120 retail allowance	Plan pays up to $45
Safety Lenses – Participant only Limited to once every 12 months Single Vision Lined Bifocal Lined Trifocal Lenticular Progressive	Plan pays 100%, up to network provider contract rates	Plan pays up to: $35 $45 $60 $90 $45
Safety Frames – Participant only Limited to once every 24 months	Effective January 1, 2017, up to $150 retail allowance. Prior to January 1, 2017, up to $120 retail allowance	Plan pays up to $25
Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Covered in Full, up to network provider contract rates	Plan pays up to $210
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	Plan pays up to $105 for contact lenses and fitting and evaluation exam	Plan pays up to $105 for exam and lenses

Covered Vision Services

- **Vision Examination** – including analysis of visual functions and prescription of corrective eyewear when indicated, once every 12 months.
- **Lenses** – once every 12 months for regular every day wear lenses and once every 12 months for safety glasses.
- **Frames** –once every 24 months for regular every day wear frames and once every 12 months for safety glasses. VSP offers a selection of frames within Plan limits. If you choose more expensive frames (exceeding the Plan limit), you will be responsible for the additional amount over the Plan's maximum.
- **Visually Necessary Contact Lenses** – once every 12 months. Visually necessary contacts obtained from a VSP Member Doctor are covered in full. When they are obtained from a non-VSP provider, an allowance will be paid toward the cost. Contact lenses are visually necessary if they are needed to restore or maintain visual acuity and a less expensive professionally acceptable alternative is not available. (Visually necessary contact lenses are subject to the exam and materials Copayments.)

  Contact lenses are provided in lieu of all other benefits for lenses and frames and only when a prescription change is warranted.

- **Elective Contact Lenses** – once every 12 months. If you choose contact lenses for any purposes other than the visually necessary circumstances described above, they are considered elective contact lenses. When you choose contact lenses instead of glasses, your $105 allowance applies to the cost of the contacts and the contact lens exam and fitting evaluation. This is in addition to your regular vision exam, which is covered in full (if from a VSP Member Doctor). When contact lenses are obtained, you will not be eligible for regular spectacle lenses again for 12 months and frames for 24 months. (Note: The exam and materials Copayments do not apply to elective contact lenses.)

Discounts From VSP Member Doctors

When you use a VSP Member Doctor, you will be entitled to discounts on charges for some non-covered items and contact lenses. These discounts include:

- 20% off for additional prescription glasses and sunglasses when a complete pair of glasses is dispensed – available from the same VSP Member Doctor who provided your eye exam within the last 12 months.

- 20%-25% savings on the most popular lens options, such as scratch resistant and anti-reflective coatings and progressives.
- 15% discount off cost of contact lens exam (fitting and evaluation).

Exclusions and Limitations

When you select any of the following extra items, the Plan will pay the basic cost of the allowed lenses or frame, and you must pay any additional cost for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating, mirror coating or scratch coating
- Blended lenses
- Cosmetic lenses, laminated lenses, or oversize lenses
- Polycarbonate lenses (covered for Dependent children)
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the Plan allowance

Services Not Covered

There are no benefits payable for professional services or materials connected with:

- Orthoptics or vision training and any supplemental testing; plano lenses (less than a +.50 diopter power); or 2 pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan that are lost or broken; except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Services that can be obtained without cost from any federal, state, county or local organization or agency.
- Corrective vision treatment of an Experimental nature.
- Costs for services and/or materials above Plan benefit allowances.

Low Vision Benefit

The Low Vision Benefit is available if you have severe visual problems that cannot be corrected with regular lenses. If you qualify for this benefit, you may receive professional services as well as ophthalmic materials, including supplemental testing, evaluations, visual training, low vision prescription services and optical and non-optical aids, subject to the maximums outlined in the following chart.

Low Vision Benefits	VSP Member Doctor	Non-Member Doctor
Supplemental testing	Covered in full	Plan pays up to $125
Supplemental Aids	75% of the approved cost	75% of the approved cost
Maximum Benefit	$500 per person, every two (2) years	

How to File a Claim

If you use a non-VSP provider, call VSP at (800) 877-7195 to have an Out-of-Network Reimbursement Form mailed or faxed to you. (You can also fill out the form online at www.vsp.com and print it.) Mail the completed form with your itemized receipt to VSP at:

When you use a VSP Member Doctor, you do not need to file a claim for reimbursement.

Vision Service Plan
Attn: Out-of-Network Provider Claims
P.O. Box 997105
Sacramento, CA 95899-7105

Appeals for Denied Vision Care Benefits

If your claim is denied, in whole or in part, you will receive written notification from VSP including the reasons for denial. If you do not agree with the denial you may then submit a written request to VSP for reconsideration within 180 days from the date you received the denial. Any request for reconsideration should include documents or records in support of your appeal. VSP will provide a written response to the appeal within 30 days after it is received.

Any request to VSP should be sent to the following address:

Vision Service Plan
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

See the brochure from VSP and "Claims and Appeals Procedures" in this booklet.

****

Vision benefits are available to you and your eligible Dependents of Plan A, B, R and Flat Rate Participants who are enrolled in the Indemnity Medical Plan. The Vision Plan is Administered by Vision Service Plan. Kaiser Participants have their vision benefits through Kaiser HMO.

Vision plan benefits are treated as standalone (or excepted) benefits under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act of 2010 (PPACA). Even though the Fund is not required to do so under PPACA, the Fund offers Vision Plan benefits for covered Dependents up to age 26.

DENTAL PLAN COVERAGE

Dental benefits are available to you and your eligible Dependents of Plan A, B, R and Flat Rate Participants whether you are enrolled in the Indemnity Medical Plan or the Kaiser HMO Plan. Dental benefits are administered by Delta Dental of California.

The following is only a brief summary of the benefits payable. See the separate Delta Dental brochure (available from the Trust Fund Office) for more information, including any restrictions on the frequency of services, exclusions and other conditions of service.

Your dental benefits are structured to provide an incentive to use dentists that belong to the Delta Dental Preferred Provider (PPO) network. You are free to use any licensed dentist but your out-of-pocket costs will be lower if you choose a Delta Dental PPO dentist.

To find a Delta PPO dentist, call Delta Dental at (800) 765-6003 or visit the website at www.deltadentalins.com.

Schedule of Dental Benefits

Dental Benefits	Delta Dental PPO Dentist	Non-PPO Dentist
Diagnostic and Preventive Benefits	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses
Basic Benefits	Plan pays 80% of covered expenses	Plan pays 50% of covered expenses
Crowns and Cast Restorations		
Prosthodontic Benefits		
Calendar Year Maximum	$2,500 per person	$2,000 per person

How To File a Claim

Any claims for dental benefits should be sent directly to Delta Dental at the following address:

Delta Dental Plan of California
P.O. Box 997330
Sacramento, CA 95899-7330

Appeals for Denied Dental Benefits

If your claim is denied, in whole or in part, you will receive written notification from Delta Dental including the reasons for denial. If you disagree with the decision, you must first exhaust Delta Dental's appeals process before filing an appeal with the Board of Trustees.

See "Claims and Appeals Procedures" in this booklet for more information.

****

Dental plan benefits are treated as standalone (or excepted) benefits under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act of 2010 (PPACA). Even though the Fund is not required to do so under PPACA, the Fund offers Dental plan benefits for covered Dependents up to age 26.

ORTHODONTIC BENEFIT FOR DEPENDENT CHILDREN

Orthodontic benefits are available to eligible Dependent children (under age 19) of Plan A, B, R and Flat Rate Participants whether you are enrolled in the Indemnity Medical Plan or the Kaiser HMO Plan. Orthodontic benefits are administered by the Carpenter Funds Office.

What the Plan Pays

Orthodontic benefits are payable at 50% of Allowed Charges and are paid in one lump sum, up to $1,500 (lifetime maximum) per Dependent child. Orthodontic benefits are provided only to Dependent children under age 19.

Orthodontic benefits are separate from the dental benefits described in the preceding section. Orthodontic benefits are administered by the Carpenter Funds Office, not Delta Dental.

Covered Services

Covered orthodontic services include corrective, interceptive, and preventive orthodontic treatment to realign natural teeth, to correct malocclusion, to provide pre-orthodontic guidance and to provide growth and development evaluation.

Exclusions

No benefits are provided for the following:

- The replacement or repair of an appliance that has been lost or damaged.
- Supplies furnished or treatment that began prior to the effective date of eligibility if you (the Participant) were not eligible for benefits at the time the orthodontic treatment commenced or if the child was not an eligible Dependent at the time treatment commenced.
- Services furnished prior to the initial installation of an orthodontic appliance. (These services may be covered under the dental plan. Contact Delta Dental at (800) 765-6003.)

How to File a Claim

Orthodontic claims can be sent to the Trust Fund Office. Send your claim to the following address:

Carpenters Health and Welfare Trust Fund for California
265 Hegenberger Road, Suite 100
Oakland, CA 94621-1480

Appeals for Denied Orthodontic Claims

The orthodontic benefit will be paid in accordance with the terms of the Plan. If you dispute any denial of benefits or the amount of any payment, you may appeal the decision as explained in “Claims and Appeals Procedures” in this booklet.

LIFE INSURANCE BENEFITS — For Plans A, B and Flat Rate

These benefits are provided through a group insurance policy with the Voya Financial/ReliaStar Life Insurance Company. If there is any discrepancy between this SPD and the Certificate of Coverage provided by Voya Financial/ReliaStar, the Certificate of Coverage will prevail.

These benefits are available to Participants, Spouses/Domestic Partners and eligible Dependent child(ren) up to age 21 who are enrolled in Plans A, B and Flat Rate (both Indemnity Medical Plan and the Kaiser HMO Plan). These benefits are not available to Participants or Dependents who are covered under Plan R.

Participant Life Insurance

$15,000 in group life insurance benefits will be paid to your beneficiary in the event of your death from any cause while eligible under the Plan.

These benefits do not apply to Participants or Dependents who are covered under Plan R.

To receive the benefit payment, the beneficiary must be living on the earlier of the following dates:

- The date the insurance company receives proof of your death.
- The tenth day after your death.

Your Beneficiary

Your beneficiary may be any person or persons you name on your enrollment form. If there is no eligible beneficiary or if you did not name one, benefits will be paid to the surviving person or persons in the following order:

Your

- spouse or domestic partner
- natural and adopted children
- parents
- brothers and sisters
- estate

If there is more than one beneficiary named, each receives an equal share of the benefit unless you have requested otherwise in writing.

You may request a change of beneficiary at any time by submitting a new enrollment form to the Trust Fund Office. If you have named an irrevocable beneficiary, the insurance company must first have the written consent of that beneficiary.

A change in beneficiary will take effect as of the date it is signed by you but will not affect any payment the insurance company makes or action it takes before receiving your notice.

Accelerated Death Benefit in Case of Terminal Illness (applicable to the Life Insurance Policy)

If it is determined that you have a terminal condition and have a life expectancy of 6 months or less, 50% of your life insurance benefit (or $7,500) may be paid to you or your legal representative while you are still living.

The benefit is paid in one lump sum and is paid only once. This lump sum payout is the only benefit option available to you prior to your death.

Applying for the Accelerated Death Benefit

To receive the Accelerated Death Benefit, **all** of the following conditions must be met. You must:

Request this benefit in writing by sending the written request to the Trust Fund Office.

If you are unable to request this benefit yourself, your legal representative may request it for you.

- Be insured as an eligible Participant for Life Insurance benefits.
- Provide to the insurance company a doctor's statement which gives the diagnosis of your medical condition, and states that because of the nature and severity of that condition, your life expectancy is no more than 6 months. The insurance company may require that you be examined by a doctor of its choosing. If the insurance company requires this, it will pay for the exam.
- Provide to the insurance company written consent from any irrevocable beneficiary, assignee and in community property states, from your spouse.

Benefit Payment

The benefit will be paid to you unless it is shown, to the satisfaction of the insurance company, that both of the following are true:

- You are physically and mentally incapable of receiving and cashing the lump sum payment; and
- A representative appointed by the courts to act on your behalf does not make a claim for the payment.

If the insurance company does not pay you because the two above conditions apply, payment will instead be made to one of the following:

- A person who takes care of you;
- An institution that takes care of you; or
- Any other person the insurance company considers entitled to receive the payments as your trustee.

Accelerated Death Benefit Exclusions

Accelerated benefits will not be paid for a terminal condition if either of the following apply:

- The terminal condition is directly or indirectly caused by attempted suicide or intentionally self-inflicted Injury, whether sane or insane; or
- The required Life Insurance premium is due and unpaid.

Effects on Life Insurance Coverage

When the Accelerated Death Benefit has been paid, your Life Insurance Coverage is affected in the following ways:

- Your life insurance benefit is reduced by the amount paid out to you as an accelerated benefit. If you received $7,500 as an accelerated benefit, your beneficiary would receive $7,500 after your death.
- Your Life Insurance benefit amount which you may convert to an individual policy is reduced by the Accelerated Death Benefit amount that has been paid.
- Any increase in the Fund's Life Insurance Benefit will not apply to you after the insurance company approves you to receive the Accelerated Death Benefit.
- You will not be able to reinstate your coverage to the full amount in the event of a recovery from a terminal condition.
- Your receipt of an Accelerated Death Benefit does not affect your Accidental Death and Dismemberment (AD&D) Insurance. If you should die in an accident after receiving an Accelerated Death Benefit, your AD&D Insurance will be based on your Life Insurance in force prior to the Accelerated Death Benefit payout, provided your premium is not being waived under the Waiver of Life Insurance Premium Disability Benefit.
- Your Dependents' Life Insurance coverage will not be affected by the Accelerated Death Benefit amount paid to you.

Waiver of Life Insurance Premium During Disability Benefit

If you become Totally Disabled before you reach age 60 and while you are eligible as an active Participant under this Plan, your group life insurance may be continued without any cost to you during that disability. This is called a Waiver of Premium.

The insurance company (Voya Financial/ReliaStar Insurance Company) needs written notice of claim before it will waive any premium. This notice must be received:

- while you are living,
- while you are totally disabled, and
- within one year from the date the total disability begins. If you cannot give Voya Financial/ReliaStar notice within one year, your claim is still valid if you show you gave notice as soon as reasonably possible. Receipt of notice or proof of Total Disability by the Trust Fund Office is not sufficient.

You must notify the Trust Fund Office promptly of your Total Disability and advise them that you want to apply for the Waiver of Premium Benefit so that the required forms can be sent to you for completion.

Voya Financial/ReliaStar will need proof of your Total Disability before any premiums can be waived. It may require you to have a physical exam by a doctor it chooses and will pay for the exam if it is required. The insurance company can only require one exam a year after premiums have been waived for 2 full years.

Termination of Waiver of Premium

Voya Financial/ReliaStar will stop waiving premiums on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give Voya Financial/ReliaStar proof of Total Disability when asked.

If the insurance company stops waiving your premium, your life insurance will not stay in force unless you meet the eligibility requirements as an Active Participant of the Trust Fund.

If you buy an individual policy under the Conversion Rights of the group policy during the first year of your disability, Voya Financial/ReliaStar will cancel the individual policy as of its issue date if within 12 months of the date you become Totally Disabled, you

- apply for the Waiver of Premium benefit and Voya Financial/ReliaStar approves it, and
- surrender the individual policy without claim, except for refund of premiums.

When Voya Financial/ReliaStar cancels your individual conversion policy, it will refund all premiums paid for the individual policy and restore your Life Insurance under the group policy Waiver of Premium Benefit. The beneficiary you named under the individual policy will be retained under the group policy unless you ask Voya Financial/ReliaStar to change the beneficiary in writing.

Continuation of Your Life Insurance If You Lose Eligibility

If your eligibility terminates, you will continue to be covered for $1,000 of your life insurance for a duration of 6 months or until you regain eligibility, whichever is earlier, IF:

- You are not eligible for the Waiver of Life Insurance Premium Disability Benefit or the Accelerated Death Benefit, and
- You are not receiving a pension from the Carpenters Pension Trust Fund for Northern California.

This continuation applies to Participant life insurance only. Your Dependent life insurance will terminate when your eligibility terminates.

However, the full amount of your insurance will be paid in the event your death occurs during the 31 days following the termination of your eligibility.

Life Insurance for Eligible Dependents (Plan A, B and Flat Rate)

If you are in Plan A, B, or Flat Rate, the following amounts of Life Insurance are provided for your eligible Dependents including Spouse/Domestic Partner and Dependent child(ren) up to age 21:

- Spouse of Domestic Partner - $500
- Children (according to age)
  From birth to 6 months of age - $100
  6 months but less than 21 years of age - $250

The amount of life insurance shown above is payable to you in the event of the death of an eligible Dependent from any cause while you are insured under the Plan.

Dependents' insurance on the lives of the insured Dependents will continue for 6 months from the date general coverage terminates, if termination is due to your death.

Right to Convert to an Individual Policy

During the 31-day period following termination of your eligibility (or your Dependent's eligibility), you or your insured Dependent may convert this life insurance (excluding any amount paid out as an accelerated death benefit) to an individual policy. Proof of good health is not required.

You or your Dependent may purchase any individual nonparticipating policy offered by the insurance company, except term insurance. The individual policy will not contain accidental death and dismemberment benefits, accelerated death benefits or disability benefits. The individual policy will be effective at the end of the 31-day period.

Proof of good health is not required to convert your insurance to an individual policy. You must apply for the individual policy and pay the first premium within 31 days of the date your eligibility ends.

If you or your insured Dependent dies within the 31-day period allowed for making application to convert, the life insurance benefit in effect prior to termination of eligibility will be paid to the beneficiary, whether or not application for a conversion policy was made. In this case, Voya Financial/ReliaStar will return any premium paid for the individual policy to your or your Dependent's beneficiary named under the group policy.

If you wish to convert your coverage to an individual policy, contact the Trust Fund Office or the insurance company at the following address for an application.

Voya Financial/ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440
Telephone Number: (800) 955-7736

If you again become eligible under the Trust Fund, conversion coverage will not again be available to you if any individual policy is in effect as a result of a previous conversion.

How to File a Life Insurance Claim

Send claims to the Trust Fund Office which will confirm eligibility and forward the claim to the insurance company. Payment of the claim will be made by the Voya Financial/ ReliaStar Life Insurance Company promptly upon receipt of all necessary proof from the Trust Fund Office.

Claims must be submitted within 90 days of the loss or as soon as reasonably possible.

Whenever there is a death claim, you should send a certified copy of the death certificate to the Trust Fund Office immediately at the following address:

Carpenters Health and Welfare Trust Fund for California
265 Hegenberger Road, Suite 100
Oakland, CA 94621-1480

Voya Financial/ReliaStar will send a proof of loss claim form within 15 days of receiving notification. This proof of loss detailing how the loss occurred must be returned to Voya Financial/ReliaStar within 91 days after the loss or as soon as reasonably possible.

Appeals for Denied Life Insurance Claims

If a claim for life insurance benefits is denied either in whole or in part, your beneficiary will receive written notification from either the Trust Fund Office or the Voya Financial/ReliaStar Life Insurance Company including the reasons for denial. If the beneficiary does not agree with the denial, he or she must submit a written request to the Voya Financial/ReliaStar Life Insurance Company requesting reconsideration within 60 days from the date he/she received the denial. Any request should include documents or records in support of the appeal. The Voya Financial/ReliaStar Life Insurance Company will provide a written response to the appeal not later than 120 days after it is received. Any request to the insurance company should be sent to:

Voya Financial/ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440

See “Claims and Appeals Procedures” in this booklet for more information.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS - For Plans A, B and Flat Rate

These benefits are provided through a group insurance policy with the Voya Financial/ReliaStar Life Insurance Company. If there is any discrepancy between this SPD and the Certificate of Coverage provided by Voya Financial/ReliaStar, the Certificate of Coverage will prevail.

The Accidental Death and Dismemberment Benefits are available to Participants ONLY who are covered under Plans A, B and Flat Rate Plans (both the Kaiser HMO Plan and the Indemnity Medical Plan). Spouses/Domestic Partners and eligible Dependent child(ren) are not covered. Participants and Dependents in Plan R are not eligible for these benefits.

The accidental death and dismemberment insurance (AD&D) benefit will be paid for any of the losses listed below if the loss is due to an accident that happens on or off the job. All of the following conditions must be met:

These benefits do not apply to Plan R Participants or to Dependents of Participants in either Plan A, B, R or Flat Rate.

- You are insured on the date of the accident,
- The loss occurs within 180 days after the accident, and
- The cause of the loss is not excluded.

Schedule of Benefits

The Full Benefit amount is $15,000 for Accidental Death.

The death benefit is paid to your beneficiary. Dismemberment benefits are paid to you in the event of loss of hands, feet, thumb, sight, speech or hearing.

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

The full Schedule of Benefits are available at the Trust Fund Office upon request.

A benefit is not paid for loss of use of the hand or foot or thumb and index finger.

The payment for all losses caused by any one accident will not be more than the Full Amount of your insurance and Voya Financial/ReliaStar will pay only one Full Amount while the Group Policy is in effect. For example, if you had an accident for which you received ½ of the Full Amount, no more than ½ of the Full Amount will be paid for the next loss.

Accidental Death and Dismemberment Exclusions

No benefit will be paid for any loss that is caused directly or indirectly by any of the following:

1. Suicide or intentionally self-inflicted Injury, while sane or insane.
2. Physical or mental Illness.
3. Bacterial infection or bacterial poisoning. **Exception:** Infection from a cut or wound caused by an accident.
4. Riding in or descending from an aircraft as a pilot or crew member.
5. Any armed conflict, whether declared as war or not, involving any country or government.
6. Injury suffered while in the military service for any country or government.
7. Injury which occurs when you commit or attempt to commit a felony.

8. Use of any drug, narcotic or hallucinogenic agent:
    - unless prescribed by a Physician,
    - which is illegal,
    - which is not taken as directed by a Physician or the manufacturer.
9. Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

How to File a Claim for Accidental Death and Dismemberment Benefits

Whenever there is a death claim, a certified copy of the death certificate should be sent to the Trust Fund Office immediately at the following address:

Carpenters Health and Welfare Trust Fund for California
265 Hegenberger Road, Suite 100
Oakland, CA 94621-1480

In cases of accidental loss of limb, sight, hearing or speech, notify the Trust Fund Office immediately, and it will send you the necessary forms so that the claim may be paid promptly. Claims must be submitted to Voya Financial/ReliaStar within 91 days or as soon as reasonably possible.

The Trust Fund Office will confirm eligibility and forward the claim to the insurance company. The insurance company will pay the claim promptly upon receipt of all necessary proof from the Trust Fund Office.

Appeals for Denied Accidental Death and Dismemberment Benefits

If a claim for accidental death and dismemberment benefits is denied either in whole or in part, you or your beneficiary will receive written notification from either the Trust Fund Office or the Voya Financial/ReliaStar Life Insurance Company including the reasons for denial. If you do not agree with the denial, you must submit a written request to the Voya Financial/ReliaStar Life Insurance Company requesting reconsideration within 60 days from the date you received the denial. Any request should include documents or records in support of your appeal. The Insurance Company will provide a written response to the appeal not later than 120 days after it is received.

Any request to the insurance company should be sent to:

Voya Financial/ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440

See “Claims and Appeals Procedures” in this booklet for more information.

SUPPLEMENTAL WEEKLY DISABILITY BENEFITS

Participants who are covered under Plans A, B and R are eligible for Supplemental Weekly Disability benefits (both Kaiser HMO Participants and Indemnity Medical Plan Participants). Participants in the Flat Rate Plan are not eligible for Supplemental Weekly Disability Benefits.

Supplemental weekly disability benefits are payable if you satisfy all of the following:

- become **temporarily** Disabled due to Illness or Injury while eligible under the Plan,
- were eligible under the Plan in each of the 12 calendar months immediately preceding the First Day of Disability provided that your eligibility is through work hours or your Hour Bank, not as a result of a disability extension of eligibility,
- worked for a Contributing Employer at least one day within the 30-day period preceding the First Day of Disability, and
- are receiving either **temporary** Workers' Compensation Benefits or State Disability Insurance benefits as a result of the Disability (or, if you live in a state that does not provide State Disability Insurance Benefits and you are not receiving Workers' Compensation Benefits, you provide written certification from a Physician approved by the Plan that you are Disabled as defined by the Plan).

Benefits are payable only to you, the Participant, and may not be assigned.

The Benefit

- The maximum benefit amount payable by the Plan is **$63 per week**.
- Benefits will begin on the 29th consecutive day of Disability.
- The maximum number of weeks payable for any one Period of Disability is 52 weeks.
- Partial weeks of Disability are payable at one-seventh of the weekly benefit amount for each full day of Disability.

The benefit amount described above will be reduced by the amount of any Social Security Disability benefit or disability pension benefit received from the Carpenters Pension Trust Fund for Northern California.

If permanent disability benefits are granted to you retroactively, the reduction to the Fund's benefit will be retroactive and you will be required to re-pay the Fund any disability benefits it paid since the effective date of your permanent benefits.

Periods of Disability

Periods of Disability will be considered separate Periods of Disability when they are:

- separated by at least 2 consecutive weeks of work for a Contributing Employer, or
- due to unrelated causes and separated by at least one full day of work for a Contributing Employer.

In any other cases, they will be considered one Period of Disability.

Definitions

"First Day of Disability" means the date you began receiving State Disability Insurance Benefits or Workers' Compensation Benefits. If you live in a state that does not provide State Disability Insurance Benefits and you are not receiving Workers' Compensation Benefits, the First Day of Disability is the date you became Disabled as certified by the attending Physician.

"Workers' Compensation Benefits" means temporary disability benefits under a Workers' Compensation Law.

"State Disability Insurance Benefits" means benefits payable in accordance with the California Unemployment Insurance code including any regulations, or benefits payable in accordance with similar statutes in any other state that provide temporary disability benefits.

Exclusions and Limitations

Benefits will not be provided for the following:

1. A Dependent's disability.
2. Any Period of Disability in excess of 52 weeks.
3. A Participant who has not been eligible under the Plan (through work hours or the hour bank) in each of the 12 calendar months preceding the First Day of Disability.
4. A Participant who has not worked for a Contributing Employer at least one day within the 30-day period preceding the First Day of Disability.
5. Any Period of Disability for which evidence of receipt of Workers' Compensation Benefits or State Disability Insurance Benefits has not been furnished to the Fund. If you reside in a state that does not provide Disability benefits and you are not receiving Workers' Compensation Benefits, no benefits will be paid unless you provide the Plan with written certification from a Physician approved by the Plan that you are Disabled as defined by the Plan.
6. A Disability for which the Plan has not received notice of claim within 12 months of the first day of Disability.
7. Any Period of Disability that begins while you are receiving COBRA Continuation Coverage.

How to File a Claim

For a claim form, go online at www.carpenterfunds.com and print the form or call the Trust Fund Office.

Send your claim for weekly disability benefits to the Trust Fund Office at the following address:

Carpenters Health and Welfare Trust Fund for California
265 Hegenberger Road, Suite 100
Oakland, CA 94621-1480

Appeals for Denied Weekly Disability Benefits

Disability benefits will be paid in accordance with the terms of the Plan. If you disagree with the decision made on your claim, you may appeal it as explained in "Claims and Appeals Procedures" in this booklet.

CLAIMS AND APPEALS PROCEDURES

There are the various types of claims associated with Plan benefits, procedures for filing claims, and the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. Throughout this section, "you" and "your" may refer to you, your Dependent(s) and/or your authorized representative, as applicable.

Use of Authorized Representative

An authorized representative, such as your Spouse or an adult child, may submit a claim or appeal on your behalf if you have previously designated the individual to act on your behalf through a form available from the Trust Fund Office. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on your behalf.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with the "urgent claims" discussed below without your having to designate an authorized representative.

Types of Claims

There are six types of claims applicable to the benefits listed at the start of this section. Four of them have to do with health care:

For information about where to submit a claim or file an appeal, please refer to the chart on page 89 of this document.

- **Pre-service claims:** A pre-service claim is a request for authorization of care or treatment that requires approval in whole or in part before the care or treatment is obtained (also called Utilization Review ("pre-authorization" or "pre-certification").

  Under this Plan, **prior approval of services** is required for the following:

  - non-emergency Hospital admissions (including mental health and substance abuse), other than stays of a certain length following childbirth or admissions when the Plan is the secondary payer (must be pre-approved by Anthem Blue Cross)
  - organ transplants (must be pre-approved by Anthem Blue Cross)
  - certain prescription Drugs (must be approved by the Plan's pharmacy benefit manager). Call Express Scripts at (800) 939-7093 for a list of the Drugs that require prior approval.
  - For the following outpatient diagnostic imaging services: CT/CTA, MR/MRI, Nuclear cardiology, PET scan and echocardiography (must be pre-approved by Anthem Blue Cross)

  If you fail to get prior approval for these services, your benefits may be denied.

- **Urgent care claims:** Your request for a required pre-authorization will be considered an urgent claim if applying the time frames allowed for a pre-service claim (*generally 15 days for a request submitted with sufficient information*) would:

  - seriously jeopardize your life or health or your ability to regain maximum function, or
  - in the opinion of a Physician with knowledge of your medical condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

  The claims evaluator, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent claim. Alternatively, if a Physician with knowledge of your medical condition determines your claim is an urgent claim and notifies the claims evaluator, it will be treated as an urgent claim.

- **Concurrent claims:** A concurrent claim is a decision that is reconsidered after an initial approval was made, resulting in a reduction, termination, or extension of the previously approved benefit. (For example, an inpatient hospital stay originally pre-approved for 5 days is subjected to concurrent review at 3 days to determine if the full 5 days are appropriate.) In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend care or treatment approved under an urgent claim.

- **Post-service claims:** Any other type of health care claim is considered a post-service claim—for example, a claim submitted for payment after health services and treatment have been obtained.

The other two types of benefit claims under this Plan are as follows:

- **Disability claims:** A disability claim is a claim for weekly disability benefits or a claim that requires a finding that you are totally disabled (for example, to receive the Disability Extension described on page 16).
- **Claims for life insurance and accidental death and dismemberment benefits** (*called "life and AD&D claims" in the text that follows*). **Note:** For information on applying for accelerated payment of life insurance benefits in the case of terminal illness, see page 73.

What is NOT a "Claim"

The following are not considered claims and are thus not subject to the requirements and time frames described in this section:

- Casual inquiries about benefits or the circumstances under which benefits might be paid
- A request for an advance determination regarding the Plan's coverage of a treatment or service that does not require Utilization Review.
- A prescription you present to a pharmacy to be filled (However, if you are required to pay the full cost to have your prescription filled, you should submit a post-service claim for the applicable reimbursement)

Filing a Claim

The method used to file a claim will depend on the type of claim:

- **Pre-service claims:**
  - **Pre-service claims under the Indemnity Medical Plan:** Have your Physician call the Anthem Blue Cross at (800) 274-7767 to request Utilization Review.
  - **Pre-service claims for prescription drug benefits:** Have your Physician call Express Scripts (the Plan's pharmacy benefit manager) at (800) 939-7093 to obtain pre-authorization for any Drug requiring Utilization Review.
- **Urgent claims:** Urgent claims (claims for Utilization Review that need to be handled on an expedited basis) should be directed to the same parties mentioned above for pre-service claims. **Urgent claims must be submitted by telephone, in person** (they may **not** be submitted via the U.S. Postal Service), or by secure email to: BCCUMintake@wellpoint.com.
- **Post-service claims:** Claim forms for post-service health care claims must be completed in full, and an itemized bill or bills must be attached.
  - **Indemnity Medical claims** (including mental health and chemical dependency) should be sent to: Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007. Contract providers will submit your claims for you. (Blue Card providers outside of California should send claims to the local Blue Cross plan.)
  - **Hearing aid and orthodontic claims** should be sent to the Trust Fund Office at the following address: Carpenters Health and Welfare Trust Fund for California, 265 Hegenberger Road, Suite 100, Oakland, CA 94621-1480.
  - **Dental claims**: Send to Delta Dental Plan of California, P.O. Box 997330, Sacramento, CA 95899-7330.
  - **Claims for prescription drug benefits:** To file a claim for reimbursement if you live more than 10 miles from a network pharmacy and have used a non-network pharmacy, if you forgot your Plan identification card and had to pay the full price at a network pharmacy, or for coordination of benefits claims if this Plan is secondary: send your claim directly to Express Scripts, P.O. Box 14711, Lexington, Kentucky 40512. You can print a claim form from the Carpenters website (www.carpenterfunds.com) or call Express Scripts customer service.

- **Claims for vision care benefits** (a claim for reimbursement if you use a provider that does not participate in the VSP network): Send directly to VSP at the following address: Vision Service Plan, Attn: Out-of-Network Provider Claims, P.O. Box 997105, Sacramento, CA 95899-7105.
- **Disability, Life and AD&D claims:** Disability claims and life and AD&D claims should be sent to the Trust Fund Office at the following address: Carpenters Health and Welfare Trust Fund for California , 265 Hegenberger Road, Suite 100, Oakland, CA 94621-1480. The Trust Fund Office will forward claims for life and AD&D benefits to the insurance company.

When Claims Must Be Filed

Your claim will be considered to have been filed as soon as it is received by the applicable claims evaluator mentioned under "Filing a Claim."

- Pre-service and urgent claims must be filed **before services are obtained**.
- You must submit all other health care claims within 90 days of when expenses are incurred, unless it is not reasonably possible to do so. **In no event will claims be paid if they are submitted more than 1 year after the date the charges were incurred**. The claim form must be completed in full, and an itemized bill or bills must be attached.
- Claims for supplemental weekly disability benefits should be submitted no later than 12 months from the First Day of Disability, but no later than 12 months.
- Claims for life and AD&D benefits should be filed **within 90 days** of the loss (does not apply to Plan R Participants).
- Disability:
  - Disability claims and life and AD&D claims should be sent to the Trust Fund Office at the following address: Carpenters Health and Welfare Trust Fund for California, 265 Hegenberger Road, Suite 100, Oakland, CA 94621-1480. The Trust Fund Office will forward claims for life and AD&D benefits to the insurance company.
  - Disability Extension, you must file an application with the Trust Fund Office **no later than 12 months from the First Date of disability as defined in the Supplemental Weekly Disability Benefits chapter of this document.**

Notification That Your Pre-Service or Urgent Claim Has Not Been Properly Filed

- If your **pre-service** claim has been improperly filed, you will be notified as soon as possible but no later than **5 days** after receipt of the claim of the proper procedures to be followed in filing a claim.
- If your **urgent** claim has been improperly filed, you will be notified as soon as possible but no later than **24 hours** after receipt of the claim of the proper procedures to be followed in filing a claim.

You will receive notice that you have improperly filed your claim only if the claim includes your name, your specific condition or symptom, and a specific treatment, service, or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

Timing of Initial Claims Decisions

A determination on your claim will be made within the following time frames:

Pre-service claims: If your pre-service health care claim has been properly filed, you will be notified of a decision within **15 days** from the date your claim is filed, unless additional time is needed.

- The time for response may be extended by up to **15 days** if necessary due to matters beyond the control of the applicable claims evaluator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the claims evaluator expects to make a decision.
- If an extension is needed because the claims evaluator needs additional information from you, the claims evaluator will notify you as soon as possible, but no later than **15 days** after receipt of the claim, of the specific information necessary to complete the claim. In that case you and/or your doctor will have **45 days**

from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either the 45 days have passed or you respond to the request (whichever is earlier). The claims evaluator then has **15 days** to make a decision and notify you of the determination. If the information is not provided within the 45 days allowed, your claim will be denied.

Urgent claims: You will be notified of a determination by telephone as soon as possible, taking into account the circumstances of your situation, but no later than **72 hours** after receipt of the claim by the claims evaluator. The determination will also be confirmed in writing.

- If your urgent claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the claims evaluator will notify you as soon as possible, but no later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must respond to this request within **2 business days**. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either the 2 business days have passed or you respond to the request (whichever is earlier). Notice of a decision will be provided no later than **48 hours** after the receipt of the required information. If the information is not provided within the 2 business days allowed, your claim will be denied.

Concurrent claims: A reconsideration that involves the termination or reduction of payment for a treatment in progress (other than by Plan amendment or termination) will be made by the claims evaluator as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

A request by you to extend treatment approved under an urgent claim will be acted upon by the claims evaluator within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment.

Post-service claims: Ordinarily, you will be notified of the decision on your post-service health care claim within **30 days** of the date the claims evaluator receives the claim. This period may be extended one time by up to **15 days** if the extension is necessary due to matters beyond the control of the claims evaluator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the claims evaluator expects to make a decision.

If an extension is needed because the claims evaluator needs additional information from you, the claims evaluator will notify you as soon as possible, but no later than **30 days** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor or dentist will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The claims evaluator then has **15 days** to make a decision on your post-service claim and notify you of the determination. If the information is not provided within the 45 days allowed, your claim will be denied.

Disability claims: The Trust Fund Office will ordinarily make a decision on the claim and notify you of the decision within **45 days** of receipt of the claim. This period may be extended by up to **30 days** if the extension is necessary due to matters beyond the control of the Trust Fund Office. If an extension is necessary, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Trust Fund Office expects to make a decision. A decision will then be made within **30 days** of when the Trust Fund Office notifies you of the delay. The period for making a decision may be extended an additional **30 days**, provided the Trust Fund Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Trust Fund Office expects to render a decision. The notification of the extension will specifically provide an explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed from you to resolve the issues.

If an extension is needed because the Trust Fund Office needs additional information from you, the Trust Fund Office will notify you as soon as possible, but no later than **45 days** after receipt of the claim, of the specific information necessary to complete the claim. You will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Trust Fund Office

then has **30 days** to make a decision on your claim and notify you of the determination. If the information is not provided within the 45 days allowed, your claim will be denied.

For disability claims, the Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

Life and AD&D claims: The insurance company will ordinarily make a decision on a claim for life or AD&D benefits within **90 days** of when it receives the claim. This period may be extended by up to **90 days** if the extension is necessary due to matters beyond the control of the insurance company. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the insurance company expects to make a decision.

Denied Claims (Adverse Benefit Determinations)

An "adverse benefit determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an adverse benefit determination:

- a payment of less than 100% of a claim for benefits
- a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any decision on a required pre-authorization or concurrent authorization
- a failure to cover an item or service because the Fund considers it to be experimental, investigational, not Medically Necessary or not medically appropriate
- a decision that denies a benefit based on a determination that you or a Dependent is not eligible to participate in the Plan

You will be provided with written notice of the initial benefit determination. If it is an adverse benefit determination, the notice will include the following:

- the specific reason(s) for the determination,
- reference to the specific Plan provision(s) on which the determination is based,
- a description of any additional material or information needed to perfect your claim and an explanation of why the material or information is needed,
- a description of the appeals procedures and applicable time limits,
- a statement of your right to bring a civil action under ERISA Section 502(a) following the appeal of an adverse benefit determination,
- if an internal rule, guideline or protocol was relied upon in deciding the claim, a statement that a copy is available upon written request at no charge, and
- if the determination was based on the absence of medical necessity, or the treatment's being experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge.

For urgent claims, the notice will describe the expedited review process applicable to urgent claims. For urgent claims, the notice may be provided orally and followed with written notification.

Appealing an Adverse Benefit Determination

If your claim is denied or you disagree with the amount of the benefit, you may ask for a review (appeal the decision) as described below.

You must submit your appeal by the applicable deadline:

- within **180 days** after you receive the notice of denial for a claim involving health care or disability (or, in the case of a concurrent claim, within a reasonable time, given the circumstances of your situation).
- within **60 days** after you receive the notice of denial for life and AD&D claims.

For guidance to Appealing an Adverse Benefit Determination, please refer to the chart on page 89 of this document.

All appeals must state the reason you are disputing the denial and be accompanied by any pertinent material not already furnished. How and where you will submit your appeal depends on what type of claim it is:

- **Pre-service claims:** Appeals of pre-service claim denials must be in writing via mail. Those involving Indemnity Medical Plan benefits should be sent to Anthem Blue Cross. Those involving prescription drug benefits should go to the pharmacy benefit manager (Express Scripts). Those involving mental health or chemical dependency benefits should go to PacifiCare Behavioral Health.
- **Urgent claims:** Appeals of urgent claim denials must be made either by telephoning or by a similarly expeditious method. Appeals of urgent claims may **not** be submitted via the U.S. Postal Service.

  Appeals of urgent claim denials should be sent to the applicable review authority mentioned in "Pre-service claims" immediately above.
- **Concurrent claims:** Appeals of adverse benefit determinations regarding concurrent claims must be made in the same manner described for urgent claims.
- **Post-service claims:** Appeals of post-service claim denials must be submitted in writing to the Trust Fund Office.
- **Disability claims:** Appeals of disability claim denials must be submitted in writing to the Trust Fund Office.

Failure to follow the proper procedures or to file an appeal within the prescribed period will constitute a waiver of your right to a review of the denial of your claim.

Review Process

The review process works as follows:

- You will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination.
- You will be provided, upon written request and free of charge, reasonable access to and copies of all relevant documents pertaining to your claim. A document is relevant if it was relied upon in making the benefit determination; it was submitted, considered, or generated in the course of making the benefit determination; it demonstrates compliance with the Plan's administrative processes and safeguards required by the regulations; or it constitutes the Fund's policy or guidance with respect to the denied treatment option or benefit. Relevant documents could include specific Fund rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Fund's rules were appropriately applied to a claim.
- A different person will review the appeal than the person who originally made the initial adverse benefit determination on the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including additional documents and comments that may be submitted by you.
- The Board may grant a personal hearing to receive and hear any evidence or argument you believe cannot be presented satisfactorily by correspondence.
- If the claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on the claim, without regard to whether the advice was relied upon in deciding the claim. Any health care professional engaged for the purpose of a consultation may not be an individual who was consulted in connection with the initial determination that is the subject of the appeal or any subordinate of such an individual.

Notice of Decision on Appeal

You will receive notice of the decision made on your appeal according to the following timetable:

- **Pre-service claims:** A notice of a decision on review will be sent within **30 days** of receipt of the appeal.
- **Urgent claims:** A notice of a decision on review will be sent within **72 hours** of receipt of the appeal.
- **Concurrent claims:** Notice of the appeal determination for a concurrent claim will be sent prior to the termination of the benefit.
- **Post-service health care claims:** Ordinarily, decisions on appeals will be made **at the next regularly scheduled meeting** of the Board of Trustees following receipt of your request for review. However, if your request for review is received less than 30 days before the next regularly scheduled meeting, it may be considered at the second regularly scheduled meeting following receipt. In special circumstances, an extension until the third regularly scheduled meeting following receipt of your request for review may be necessary. If such an extension is necessary, you will be advised in writing of the special circumstances and the date by which a decision will be made before the extension begins. Once a decision has been reached, you will be notified as soon as possible, but no later than 5 days after the date of the decision.
- **Disability claims:** Decisions on appeals will be made at Board of Trustees meetings. Timing and procedures are the same as those described immediately above for post-service health care claims.
- **Life and AD&D claims:** Decisions will ordinarily be made within **60 days** of receipt of appeal by the insurance company. The period for making a decision may be extended by up to **60 days**, provided the insurance company notifies you, prior to the expiration of the first 60 days, of the circumstances requiring the extension and the date as of which the insurance company expects to render a decision.

If Your Appeal is Denied

The determination of an appeal will be provided to you in writing. The notice of a denial of an appeal will include the following:

- the specific reason(s) for the determination,
- reference to the specific Plan provision(s) on which the determination is based,
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to the claim, upon written request and free of charge,
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal,
- if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon written request at no charge, and
- if the determination was based on medical necessity, the treatment's being experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge.

For any claims asserted under the Plan or against the Fund or the denial of a claim to which the right to review has been waived, the decision of the Board or its designated Appeals Committee with respect to a petition for review is final and binding upon all parties, subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration.

When a Lawsuit May Be Started

If you believe the rules of the Plan were not applied appropriately in the decision made on your appeal, you may file a lawsuit in Federal court against the Plan. However, no legal or equitable action for benefits under this Plan shall be brought unless and until you have:

- submitted a claim for benefits pursuant to the Plan's Rules and Regulations,
- been notified that the claim is denied (or the claim is deemed denied),

- requested a review of the adverse benefit determination and exhausted all administrative procedures, including all claim appeal and review procedures for every issue you deem relevant, and
- been notified in writing that the denial of the claim has been confirmed (or the claim is deemed denied) on review.

("Deemed denied" means that you filed a claim or an appeal and had not received a decision or notice that an extension would be necessary by the expiration of the response time allowed for the type of claim.)

No legal action may be started or maintained more than two (2) years after the date you have been notified in writing that the denial of the claim has been confirmed on review.

Discretionary Authority of the Board of Trustees

The Board of Trustees has the exclusive right and discretion to construe and interpret the Plan and is the sole judge of the standard of proof required in any claim and the application and interpretation of the Plan. Any dispute as to eligibility, type, amount or duration of benefits or any right or claim to payments from the Fund will be resolved by the Board or its duly authorized designee under and pursuant to the provisions of the Plan and the Trust Agreement, and its decision is final and binding upon all parties, subject only to judicial review as may be in harmony with federal labor law.

Where to Submit a Claim or File an Appeal

	CLAIMS	APPEALS
Kaiser Foundation Health Plan (including medical, prescription, hearing aid, and vision)	Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923	Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623
Indemnity Medical Plan (including mental health and chemical dependency)	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480
Indemnity Plan – Prescription Drug Benefits	Express Scripts P.O. Box 14711 Lexington, Kentucky 40512	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480
Indemnity Plan – Vision Care Benefits	Vision Service Plan Attn: Out-of-Network Provider Claims P.O. Box 997105 Sacramento, CA 95899-7105	Vision Service Plan Member Appeals 333 Quality Drive Rancho Cordova, CA 95670
Indemnity Plan – Hearing Aid Benefits	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480
Dental Benefits	Delta Dental Plan of California P.O. Box 997330 Sacramento, CA 95899-7330	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480
Orthodontic Benefits	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480
Life Insurance Benefits and Accidental Death and Dismemberment Benefit	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480	Voya Financial/ReliaStar Life Insurance Company P.O. Box 20 Minneapolis, Minnesota 55440
Supplemental Weekly Disability Benefits	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480

INDEMNITY COORDINATION OF BENEFITS (COB) AND THIRD PARTY LIABILITY

Coordination of Benefits with Other Plans

If an Eligible Individual is entitled to benefits from another Group Plan for health care expenses for which benefits are also due from this Fund, then the benefits provided by this Plan will be paid in accordance with the following provisions, not to exceed the dollar amount of benefits that would have been paid in the absence of other group coverage or 100% of the Covered Expenses actually incurred by the Eligible Individual.

1. The benefits of the plan that covers the person as a participant, employee or subscriber are always determined before the benefits of a plan covering the person as dependent. This provision applies to any Dependent child who is covered under another plan as a participant, employee or subscriber.

2. If you are the Dependent Spouse of a Participant, Fund benefits will be paid for eligible expenses not covered by the other Group Plan.

Important Notice if Your Spouse Is Employed

If a Spouse is offered the opportunity to enroll in another Group Plan sponsored by the Spouse's employer and elects not to enroll in that Group Plan, the benefits of that Group Plan will be determined before THIS Plan's benefits, regardless of whether or not the Spouse has actually enrolled in the other Group Plan and regardless of whether the Spouse's Employer requires a premium payment. The Plan will estimate the other Group Plan benefits at 80% of Covered Expenses.

3. If a claim is made for a Dependent child whose parents are not separated or divorced, the benefits of the Group Plan that covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year, will be determined before the benefits of the Group Plan that covers that Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs later in the calendar year.

   If either Group Plan does not have the provisions of this rule regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this rule will not apply, and the rule set forth in the Plan that does not have the provisions of this rule will determine the order of benefits.

4. If a claim is made for a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan that covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a Plan that covers the child as a Dependent of the parent without custody.

5. If a claim is made for a Dependent child whose parents are separated or divorced and the parent with custody of the child has remarried, the benefits of a Plan that covers the child as a Dependent of the parent with custody will be determined before the benefits of a Plan that covers the child as a Dependent of the stepparent, and the benefits of a Plan that covers that child as a dependent of the stepparent will be determined before the benefits of a Plan that covers that child as a dependent of the parent without custody.

6. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree that would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then notwithstanding rules 4 and 5 above, the benefits of a Plan that covers the child as a Dependent of the parent with financial responsibility will be determined before the benefits of any other plan that covers the child as a Dependent child.

7. For a Dependent child who is covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined under the longer/shorter length of coverage rule described below and if length of coverage is the same, then the birthday rule (number 3 above) will apply between the Dependent child's parents coverage and the Dependent's spouse's coverage. For example, if a married Dependent child on this Plan is also covered as a Dependent on the group plan of their spouse, this Plan looks to the length of coverage rule first, determining benefits under the Plan that covered the Dependent child longer first, and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year.

When rules 1, 2, 3, 4, 5, 6 and 7 do not establish an order of benefit determination, Fund benefits will be provided without reduction, if the Eligible Individual has been eligible continuously for benefits from this Fund for a longer period of time than he or she has been continuously eligible for benefits from the other Group Plan, provided that:

- The benefits of a Group Plan covering the Eligible Individual on whose expenses claim is based as a laid-off or retired Participant, or Dependent of that person, will be determined after the benefits of any other Group Plan covering that person as an active employee or dependent of an active employee; and
- If either Group Plan does not have a provision regarding laid-off or retired employees, which results in each Group Plan determining its benefits after the other, then the provision (a) above will not apply.

Coordination with Preferred Provider Agreements

In addition to any other limitations applicable to this Plan or its Coordination of Benefits provisions, where this Plan, as "secondary", is coordinating benefits with another plan that has entered into a Preferred Provider Agreement with a medical or hospital provider, this Plan will pay no more than the difference between:

1. The lesser of:
   - the normal charges billed for the expenses by the provider;
   - the contractual rate for that expense under the Preferred Provider Agreement between the provider and the Plan that this Plan is coordinating with, or
   - this Plan's contractual rate with its preferred provider; and
2. The amount that the other plan pays as "primary."

Coordination with Medicare

The Fund will provide normal hospital and medical benefits under the Indemnity Medical Plan for active Eligible Participants and their Spouses and Domestic Partners. If an expense is covered by both this Plan and Medicare (except for charges incurred after the first 30 months of treatment of end-stage renal disease), this Plan will pay its benefits without regard to Medicare, and Medicare may then pay the remainder of the charge subject to its applicable limitations.

Coordination with Medicaid

Benefits payable by this Plan will be made in compliance with any assignment of rights made by or on behalf of an Eligible Individual as required by California's plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

If the State has provided medical assistance (under Medicaid) where this Plan has a legal liability to make payment for services, payment will be made by this Plan for claims submitted within one year from the date expenses were incurred. Reimbursement to the State, like any other entity that has made payment for medical assistance where this Plan has a legal liability to make payment, will be equal to Plan benefits or the amount actually paid, whichever is less.

Coordination with Prepaid Plans (such as HMOs)

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event a Participant or Dependent:

- has coverage under the Indemnity Medical benefits of this Plan, and

- has coverage under a prepaid program under another Group Plan (regardless of whether the Participant or Dependent must pay a portion of the premium for that plan), and
- uses the prepaid program,

then this Plan will only reimburse the Copayments required of the Eligible Participant or Dependents under the prepaid program, and only if Copayments are required of every person covered by that program.

Third-Party Liability

If an Eligible Individual has an Illness, Injury, disease or other condition for which a third party (or parties) is or may be liable or legally responsible by reason of an act, omission, or insurance coverage of that third party or parties (referred to in this SPD collectively as "responsible third party"), the Fund will not be liable to pay any benefits. However, upon the execution and delivery to the Fund of all documents it requires to secure the Plan's right of reimbursement, including without limitation a Reimbursement Agreement, the Fund may pay benefits on account of hospital, medical or other expense in connection with, or arising out of, that Injury, Illness, disease or other condition. The Fund will have all rights as outlined in the Third-Party Liability section (Section 8.02) of the Rules and Regulations printed at the end of this SPD (beginning on page 44 of that document).

The Fund shall be reimbursed first, before any other claims, for 100% of benefits paid by the Fund from any recovery received by way of judgment, arbitration award, verdict, settlement or other source by the Eligible Individual or by any other person or party for the Eligible Individual, pursuant to such Illness, Injury, disease or other condition, including recovery from any under-insured or uninsured motorist coverage or other insurance, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. The Fund shall be reimbursed from said recovery without any deduction for legal fees incurred or paid by the Eligible Individual. The Eligible Individual and/or his or her attorney must promise not to waive or impair any of the rights of the Fund without written consent. In addition, the Fund shall be reimbursed for any legal fees incurred or paid by the Fund to secure reimbursement of said benefit paid by the Fund.

If the Fund pays any benefits because of such Illness, Injury, disease or other condition, the Fund shall also have an automatic lien and/or constructive trust on that portion of any recovery obtained by the Eligible Individual or by any other person or party for the Eligible Individual, for such Illness, Injury, disease or other condition which is due for said benefits paid by the Fund, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. Such lien may be filed with the Eligible Individual, his or her agent, insurance company, any other person or party holding said recovery for the Eligible Individual, or the court; and such lien shall be satisfied from any recovery received by the Eligible Individual, however classified, allocated, or held.

If reimbursement is not made as specified, the Fund, at its sole option, may take any legal and/or equitable action to recover the amount that was paid for the Eligible Individual's Illness, Injury, disease or other condition (including any legal expenses incurred or paid by the Fund) and/or may offset future benefits payments by the amount of such reimbursement (including any legal fees incurred or paid by the Fund). The Fund, at its sole option, may cease paying benefits, if there is a reasonable basis to determine that the Eligible Individual will not honor the terms of the Plan, or there is a reasonable basis to determine that this section is not enforceable.

GENERAL PROVISIONS/INFORMATION REQUIRED BY Employee Retirement Income Security Act of 1974 (ERISA)

General Plan Information

The name and type of administration of the Plan:

The name of the Plan is Carpenters Health and Welfare Trust Fund for California. The Plan Sponsor is the Joint Board of Trustees of the Carpenters Health and Welfare Trust Fund for California. The Administrative Office of the Fund is located at the following address:

Carpenter Funds Administrative Office of Northern California, Inc.
265 Hegenberger Road, Suite 100
Oakland, CA 94621-1480
Phone: (510) 633-0333
Email: benefitservices@carpenterfunds.com
Website: www.carpenterfunds.com

The Trust Fund Office will provide any Plan Participant or beneficiary, upon written request, information as to whether a particular Employer is contributing to this Fund and, if so, that Employer's address.

Type of plan:

The Plan is an employee welfare benefit plan, providing life insurance, accidental death and dismemberment, weekly disability, medical, prescription drug, hearing aid, vision care, dental, and orthodontic benefits to Participants and their eligible Dependents.

Internal Revenue Service identification number and Plan number:

The Employer Identification Number (EIN) issued to the Board of Trustees is 94-1234856. The Plan number is 501.

Name and address of the person designated as agent for the service of legal process is:

Gene H. Price, Administrator
c/o Carpenters Health and Welfare Trust Fund for California
265 Hegenberger Road, Suite 100
Oakland, CA 94621-1480

Service of legal process may also be made upon the Board of Trustees or an individual Trustee.

This program is maintained pursuant to various collective bargaining agreements.

Copies of the collective bargaining agreements are available for inspection at the Trust Fund Office during regular business hours, and upon written request, will be furnished by mail. A copy of any collective bargaining agreement that provides for contributions to the Fund will also be available for inspection within 10 calendar days after written request at any of the Local Union offices or at any office of any Contributing Employer to which at least 50 Plan Participants report each day.

Names, titles and addresses of any Trustee or Trustees:

Employer Trustees

Don Dolly
ACME General Engineering, Inc.
P.O. Box 1574
Oakdale, CA 95361

Labor Trustees

Robert Alvarado
Northern California Carpenters Regional Council
265 Hegenberger Road, Suite 200
Oakland, CA 94621

Randy Jenco
Viking Construction Company
P.O. Box 1508
Rancho Cordova, CA 95741

Augie Beltran
Northern California Carpenters Regional Council
265 Hegenberger Road, Suite 200
Oakland, CA 94621

Mike Mencarini
Unger Construction Company
910 X Street
Sacramento, CA 95818

Frank Crim
Carpenters Local Union No. 180
404 Nebraska Street
Vallejo, CA 94590

Larry Nibbi
Nibbi Brothers General Contractors
100 Brannan Street, Suite 102
San Francisco, CA 94103

William Feyling
Carpenter 46 Northern California Counties
Conference Board
265 Hegenberger Road, Suite 220
Oakland, CA 94621

Chuck Palley
Cahill Contractors, Inc.
425 California Street, Suite 2200
San Francisco, CA 94104

Curtis Kelly
Northern California Carpenters Regional Council
265 Hegenberger Road, Suite 200
Oakland, CA 94621

Joseph R. Santucci
The Conco Companies, Inc.
5141 Commercial Circle
Concord, CA 94520

Timothy Lipscomb
Northern California Carpenters Regional Counsel
265 Hegenberger Road, Suite 200
Oakland, CA 94621

Roy Van Pelt
Lathrop Construction Associates, Inc.
4001 Park Road
Benicia, CA 94510

Tom Mattis
Carpenters Local Union No. 751
1706 Corby Avenue
Santa Rosa, CA 95407

The Plan's requirements with respect to eligibility for benefits

Please refer to the eligibility section of this SPD beginning on page 7

Certain factors could interfere with payment of benefits from the Plan (result in your disqualification or ineligibility, denial of your claim, or loss, forfeiture, or suspension of benefits you might reasonably expect).

Examples of such factors are listed below. See also any other sources of information that apply to you: your Evidence of Coverage from Kaiser (if you are enrolled in Kaiser), the dental benefits brochure from Delta Dental, the vision benefits brochure from VSP (if you are enrolled in the Indemnity Medical Plan).

- **Performance of Non-Qualifying Employment.** If the Fund is notified that you have performed work other than work under a collective bargaining agreement or Subscriber Agreement requiring contributions to the Fund, your eligibility will terminate the first day of the next month.
- **Cancellation of your Hour Bank (*Plan A and Plan B Participants Only*).** The hours in the Hour Bank that provide your eligibility will be reduced to zero if you fail to report the existence of other employer-supported group health coverage, knowingly permit a Contributing Employer to contribute for less than all the hours you worked, except as provided by the collective bargaining agreement, or perform work of the type covered by the Plan for an employer who is not a Contributing Employer or your employer fails to pay the reported contributions for you for 4 consecutive months. See page 10 and12 for details.

- **Overlooking the Plan's requirements for Utilization Review.** Certain Indemnity Medical Plan benefits will not be payable if you fail to follow the Plan's requirements for Utilization Review. See page 56 for information on the Indemnity Medical Plan's Utilization Review requirements. Other benefits (such as prescription drugs and mental health and chemical dependency) have Utilization Review requirements too.
- **Use of a Non-Contract Providers.** You will not receive the highest level of coverage available for many of the health care services described in this booklet unless you use Contract Providers (also called "participating" or "network" providers or, in the case of dental benefits, "PPO dentists"). For some services and supplies, you will not receive any benefits if you do not use Contract Providers. See the sections on the health care benefits for more information.
- **Failure to submit claims in a timely way.** You should submit all health care claims within 90 days from the date on which covered expenses were incurred. In no event will benefits be allowed if you file a claim more than 1 year from the date on which expenses were incurred.
- **Prescription Drugs.** Not securing specialty medications through the Specialty Pharmacy carrier, not receiving a prior authorization for certain medications, or not purchasing long-term drugs under the Mail Order Pharmacy will result in a denial of your prescription drug claim. Specialty Pharmacy medications are drugs that treat rare and complex conditions such as hemophilia, cancer, multiple sclerosis, rheumatoid arthritis, hepatitis C, or psoriasis. Benefits for these types of medications are only available through the Plan's Pharmacy Benefit Manager / Specialty Pharmacy carrier. Like some medical services, some medications require a prior authorization before benefits are payable and coverage for long-term medications (drugs that requires more than two refills) is limited to purchases with the Mail Order Pharmacy.

Note: Both Plan A and Plan R Participants are required to notify the Trust Fund Office of other coverage. If you don't notify the Fund of other insurance, it may be unable to coordinate your benefits and this could result in an overpayment on your claim. Overpayments must be repaid before any future claims for you and your family can be paid.

- **The Plan's provisions for coordination of benefits.** If you or a Dependent has health care coverage under another plan, payment of benefits will be coordinated with payment of benefits by that other plan. See "Coordination of Benefits" on page 90 for more information.
- **Failure of your Spouse to enroll in a group plan sponsored by your Spouse's employer.** If your Spouse has the opportunity to enroll in employer-sponsored coverage even if your spouse is required to pay 100% of the cost, the Fund will coordinate benefits as if your Spouse is enrolled in that coverage even if he or she has elected not to enroll. The Fund will assume the other plan pays 80% of your Spouse's covered expenses and adjust its benefits accordingly.
- **The Plan's provisions regarding payment from another source.** You will be required to reimburse the Fund for benefits it pays if you or a Dependent is injured by the acts of a third party and you collect payment for that injury from another source. See "Third-Party Liability" on page 90 for more information.
- **Not keeping your address up to date.** If you move, it is your responsibility to keep the Trust Fund Office informed about where it can reach you. Otherwise, you may not receive important information about your benefits.
- **Lack of maintaining your work hours records.** Eligibility will be granted only to the extent that contributions have been received by the Fund. The Fund presumes that your hours and contributions are accurate unless you have challenged the accuracy of a quarterly statement within one year of receipt of that statement. It is very important that you retain your check stubs or statements as a basis for checking the accuracy of your Health and Welfare benefits. If your hours do not agree with the hours to which you believe you are entitled, you should ask the Trust Fund Office to review the contribution records. In order to file a claim for under-reported hours, you must provide proof that hours reported to the Trust Fund Office are less than the hours you worked in covered employment for which Health and Welfare contributions were required. You must retain payroll check stubs, which will be required to investigate a claim of under-reporting. Check stub evidence must include the names of Employers for whom you worked, the dates of work, and wages paid. Written requests for review must be received within one year of the date of receipt of your Combined Quarterly Statement.
- **Working as a "Stakeholder".** If you are working as a "Stakeholder", certain Plan benefits are not available to you such as Disability Extension benefits, Supplemental Weekly Disability benefits or COBRA Continuation coverage. As a "Stakeholder", you will only be eligible for coverage if all contributions due on behalf of all hours for all employees working for your Employer are current and all delinquencies are resolved. You will not be granted coverage unless and you have averaged 145 hours during the three most current work months and those hours have been reported to the Fund. Furthermore, Hour Bank coverage is not available to you unless you are no longer in the employ of your previous Employer in any capacity, and are no longer a Stakeholder as defined by the Plan.

  A "Stakeholder" is an owner, partner, shareholder, member of the board of directors of a corporation, officer of an individual employer, superintendent above the rank of foreman or general foreman, or other individual who is in any other way interested in the profits of the employer.

See also the Enrollment and Eligibility chapter on page 7 for more information on eligibility and termination of eligibility.

Source of financing of the Plan and identity of any organization through which benefits are provided:

All contributions to the Fund are made by Contributing Employers in compliance with collective bargaining agreements in force with the Carpenters 46 Northern California Counties Conference Board or one of its affiliated Local Unions, or by the Regional Council or one of its affiliated Local Unions with respect to certain of their Participants pursuant to Board regulations, or a recognized Subscriber Agreement.

Contributions are calculated pursuant to the applicable Collective Bargaining Agreement or Subscriber Agreement.

Benefits are provided through the Carpenters Health and Welfare Trust Fund for California and the organizations shown in the chart in the following section.

The date of the end of the Plan Year:

The date of the end of the Plan Year is August 31.

Claims and Appeals Procedures

Claims and appeals procedures are described in the section of this booklet starting on page 81. Also, refer to page 88 of this document for information regarding where to submit a claim or file an appeal.

Future of the Plan and Trust; Plan Amendment and Termination Rights:

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

The Board of Trustees has the right to change or discontinue both the types and amounts of benefits under this Plan and the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

The Plan may be terminated pursuant to the authority under the Trust Agreement. In the event of termination of the Trust, any and all monies and assets remaining in the Trust, after payment of expenses, will be used for the continuance of the benefits provided by the then existing program of benefits, until these monies and assets have been exhausted. The Board of Trustees has the right to revise, reduce, or otherwise adjust benefits in any reasonable manner in connection with termination of the Plan.

Organizations Through Which Benefits Are Provided

Name and Address of Organization	
Anthem Blue Cross of California 21555 Oxnard Street Woodland Hills, CA 91367 Administers Contract Provider program and required Utilization Review for Indemnity Medical Plan. (Benefits are self-funded by the Trust Fund.)	**Delta Dental Plan** 100 First Street San Francisco, CA 94105 Administers the dental plan for Participants enrolled in the dental plan. (Benefits are self-funded by the Trust Fund.)
Kaiser Foundation Health Plan Northern California Region 1950 Franklin Street Oakland, CA 94612 Provides prepaid medical, drug, vision and hearing aid benefits to Participants enrolled in Kaiser.	**Express Scripts** Administers prescription drug benefits for Indemnity Medical Plan Participants; does not guarantee payment of prescription drug benefits. (Benefits are self-funded by the Trust Fund.) **Accredo** 1640 Century Center Pkwy Memphis, TN 38134 Administers the Specialty Pharmacy benefits for the Indemnity Medical Plan.

Name and Address of Organization	
Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 Administers vision plan for Participants in the Indemnity Medical Plan. (Benefits are self-funded by the Trust Fund.)	**Voya Financial/ReliaStar Life Insurance Company** P.O Box 20 Minneapolis, MN 55440 Insures the life insurance and accidental death and dismemberment benefits.

Your ERISA Rights

As a Participant in the Carpenters Health and Welfare Trust Fund for California, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, Spouse, or Dependent children 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 SPD and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace** (*the Marketplace helps people without health coverage find and enroll in a health plan, [for California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov*)].

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court

may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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 once you have exhausted the appeals process described in "Claims and Appeals Procedures" in this booklet. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

No legal action may be started or maintained more than two years after the date the claimant has been notified in writing that the denial of the claim has been confirmed on review.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

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 obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA toll free at (866) 444-EBSA (3272) or contacting the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices at the website of EBSA at www.dol.gov/ebsa.

Rebates

In the event that the Health and Welfare Plan receives a "Medical Loss Ratio" (MLR) Rebate, the monies received will be used for the exclusive purpose of providing benefits to participants in the Plan and their beneficiaries and defraying reasonable expenses of administering the plan.

Headings, Font and Style Do Not Modify Plan Provisions

The headings of chapters and subchapters and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

Privacy of Health Information

The Plan is required to protect the confidentiality of your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

If you need another copy of the Plan's Notice of Privacy Practices, notices are available online at www.carpenterfunds.com or contact the Trust Fund Office.

The Plan's Notice of Privacy Practices, distributed to all Plan Participants and Dependents when they first become eligible, explains what information is considered "Protected Health Information (PHI)." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information. (See Section 10.09.d. of the Rules and Regulations printed at the end of this SPD for more information, including a definition of Protected Health Information.)

Your rights under HIPAA include the right to:

- Receive confidential communications of your protected health information, as applicable;
- See and copy your health information;

- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan's Privacy Official or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

In compliance with HIPAA Security regulations, the Plan has implemented administrative, physical and technical safeguards that protect the confidentiality and integrity of electronic PHI that it creates, receives, maintains or transmits.

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

RULES AND REGULATIONS
For
Plan A, Plan B, Plan R and Flat Rate Plan
ACTIVE PARTICIPANTS

Amended and Restated Effective November 1, 2016

Through Amendment #54 for Plan A and Plan R, Amendment #52 for Plan B and Flat Rate Plan; and Amendment #1 for Plans A, B, R and Flat Rate
(Effective November 1, 2016)

ARTICLE 1. DEFINITIONS

Unless the context or subject matter otherwise requires, the following definitions will govern in these Rules and Regulations:

Section 1.01. The term "Allowed Charge" means the lesser of:

a. The dollar amount this Fund has determined it will allow for covered Medically Necessary services or supplies performed by Non-Contract Providers. The Fund's Allowed Charge amount is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), usual, customary and reasonable (UCR), prevailing or any similar term. A charge billed by a provider may exceed the Fund's Allowed Charge. The Fund reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the amount the Fund will allow for submitted claims. When using Non-Contract Providers, the Eligible Individual is responsible for any difference between the actual billed charge and the Fund's maximum Allowed Charge, in addition to any copayment and percentage coinsurance required by the Plan.

b. The Provider's actual billed charge.

c. The Fund has adopted a Medicare based reimbursement strategy for Non-Contract Hospital, Non-Contract Facility and other Non-Contract Providers where the maximum amount payable by this Plan is a percentage of the amount that would have been payable in accordance with Medicare allowable payments. The Plan limits Medically Necessary *out-patient* services from Non-Contract Providers who are not registered with the Centers for Medicare & Medicaid Services (CMS) to a maximum allowable charge of $100 per appointment, subject to the non-PPO deductible and coinsurance. Benefits paid *for in-patient* services from a Non-Contract Provider is based on a percentage of that provider's CMS registered fee; there will be no benefits available for in-patient services from a Non-Contract Provider who is not registered with CMS.

Section 1.02. The term "Board" means the Board of Trustees established by the Trust Agreement.

Section 1.03. The term "Chiropractor" means a practitioner who specializes in the restoration of normal function of the nerve system by manipulation and treatment of the structures of the human body, especially those of the spinal column.

Section 1.04. The term "Coinsurance" means that portion of eligible expenses for which the covered person has financial responsibility to pay. Coinsurance amounts are addressed in Article 3.

Section 1.05. The term "Coinsurance Maximum" means the maximum amount of Coinsurance each covered person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply (for most but not all services). When the Coinsurance Maximum is reached, the Plan will pay 100% of additional coinsurance related to most covered expenses for the remainder of the Calendar Year. There is no Coinsurance Maximum for Non-Contract provider expenses.

Section 1.06. The term "Concurrent Review" means the process whereby the Professional Review Organization (PRO) determines the number of authorized Hospital days considered Medically Necessary that are eligible for unreduced benefit coverage according to the terms of the Plan. This occurs after an Eligible Individual has been admitted to a Hospital.

Section 1.07. The term "Contract Hospital" means a Hospital that has a contract in effect with the Fund's Preferred Provider Organization. (PPO)

Section 1.08. The term "Contract Facility" means a health care or substance abuse treatment facility that has a contract in effect with the Fund's Preferred Provider Organization. (PPO)

Section 1.09. The term "Contract Physician" or "Contract Provider" means a physician or other health care provider that has a contract in effect with the Fund's Preferred Provider Organization. (PPO)

Section 1.10. The term "Contributing Employer" means any employer who is required by any of the collective bargaining agreements, memorandums of understanding, or Subscriber's Agreements to make contributions to the Fund, and who does in fact make one or more contributions to the Fund.

The term "Contributing Employer" also includes any Local Union or Regional Council, any labor council or other labor organizations with which a Local Union or Regional Council is affiliated, and any corporation, trust or other entity which provides services to the Fund or in the enforcement or administration of contracts requiring contributions to the Fund, or in the training of apprentice or journeyman carpenters, which makes contributions to the Fund with respect to the work of its Participants pursuant to a Subscriber's Agreement and approved by the Board of Trustees, provided the inclusion of any Local Union, Regional Council, labor council, other labor organization, corporation, trust or other entity as a Contributing Employer is not a violation of any existing law or regulation. Any Local Union, Regional Council, labor council, other labor organization, corporation, trust or other entity is a Contributing Employer solely for the purpose of making contributions with respect to the work of its respective Participants and has no other rights or privileges under the Trust Agreement as a Contributing Employer.

Section 1.11. The term "Copayment" means the amount the Eligible Individual is required to pay for a service or Drug before Plan benefits are payable.

Section 1.12. The term "Covered Expense(s)" means only those charges which are Allowed Charges under the Plan and that are made for the Medically Necessary care and treatment of a non-occupational Illness or Injury, except that certain routine preventive services are considered Covered Expenses when specifically provided in the Plan. Covered Expenses include only those charges incurred by an Eligible Individual while eligible for benefits under this Plan. In no event will a Covered Expense exceed either the Allowed Charge for a service provided by a Non-Contract Provider, or for a Contract Provider, the contractual rate for the service under a Preferred Provider Agreement.

Section 1.13. The term "Deductible" means the amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. An individual Deductible applies to an individual person, while the family Deductible applies to all members of the family that are covered under the Plan. Everything paid toward an individual Deductible counts toward the family Deductible. The amount of Deductibles is discussed in Section 3.01.

Section 1.14. The term "Dentist" means a dentist licensed to practice dentistry in the state in which he or she provides treatment.

Section 1.15. The term "Dependent" means:

- The Participant's lawful spouse or qualified Domestic Partner.

- A child who is:

  (1) the Participant's natural child, stepchild or legally adopted child, or a child of the Participant required to be covered under a Qualified Medical Child Support Order, who is younger than 26 years of age, whether married or unmarried. Adopted children are eligible under the Plan when they are placed for adoption.

  (2) an unmarried child for whom the Participant has been appointed legal guardian, provided the child is younger than 19 years of age and is considered the Participant's dependent for federal income tax purposes;

  (3) an unmarried child of the Participant's qualified Domestic Partner, provided the child is younger than 19 years of age and is primarily dependent on the Participant for financial support;

  (4) an unmarried child eligible under paragraph (2) or (3) above other than age who is 19 but less than 23 years of age and a full time student at an accredited educational institution, provided the child otherwise meets the requirements of paragraph (2) or (3) above. Temporary absence from the Participant's place of abode due to education is not treated as absence for purposes of satisfying the residence requirement of paragraphs (2) and (3) of this Subsection; or

(5) an unmarried child of the Participant (or the Participant's spouse or qualified Domestic Partner) of any age who is prevented from earning a living because of mental or physical handicap, provided the child was disabled and eligible as a Dependent under this Plan before reaching the Limiting Age described in paragraphs (1), (2), (3) or (4) above, and provided the child is primarily dependent on the Participant for financial support.

c. In accordance with ERISA Section 609(a), this Plan will provide coverage for a child of a Participant if required by a Qualified Medical Child Support Order, including a National Medical Support Order. A Qualified Medical Child Support Order or National Medical Support Order will supersede any requirements in the Plan's definition of Dependent stated above.

Section 1.16. The terms "Disabled" and "Disability" mean:

a. For purposes of the Disability Extension described in Section 2.05 and the Supplemental Weekly Disability Benefits in Article 7., that the Participant is under a Physician's care and is unable to work at his or her regular occupation due to Illness or Injury, be in receipt of Workers' Compensation Benefits, or where available State Disability Insurance Benefits (SDI) or the claim effective date established by State Disability Insurance.

b. For purposes of the Extension of Benefits for Disability in Section 3.08, that due to Illness or Injury and while under a Physician's care, a Participant is unable to engage in any employment for wage or profit, and a Dependent is prevented from performing all regular and customary activities usual for a person of similar age.

c. The term "Temporarily Disabled" means that due to Illness or Injury and while under a Physician's care, a Participant is unable to engage in any employment for wage or profit, and a Dependent is prevented from performing all regular and customary activities usual for a person of similar age, and the period of disability lasts for 6 months or less. Periods of Disability will be considered separate Periods of Disability when they are separated by at least 2 consecutive weeks of work for a Contributing Employer, or are due to unrelated causes and separated by at least one full day of work for a Contributing Employer.

Section 1.17. The term "Domestic Partner" means a person who resides with the Participant in the same residence, is at least 18 years of age and whose relationship with the Participant meets the following requirements:

a. The Domestic Partner and the Participant have had an intimate, committed relationship of mutual caring for a period of at least 6 months and are each other's sole domestic partner;

b. The Domestic Partner and the Participant share joint responsibility for each other's common welfare and financial obligations and can submit proof of their relationship as required by the Board of Trustees;

c. Neither the Domestic Partner nor Participant is married;

d. The Domestic Partner and Participant are each competent to contract;

e. The Domestic Partner and Participant are not related by blood closer than would prohibit legal marriage in the State of California;

f. Any prior domestic partnership of either person has been terminated not less than 6 months prior to the date of the signing of the final declaration of domestic partnership with the Trust Fund Office; and

g. Application for domestic partnership with the Participant is properly made as required by the Board of Trustees and all required taxes on the imputed income attributable to Domestic Partner benefits are paid to the Fund when due.

Section 1.18. The term "Drugs" means any article which may be lawfully dispensed under the federal Food, Drug and Cosmetic Act including any amendments, only upon a written or oral prescription of a Physician or Dentist licensed by law to prescribe it.

Section 1.19. The term "Eligible Individual" means each Participant and each of his/her Dependents, if any.

Section 1.20. The term "Emergency Care/Emergency" means medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to place the Patient's life or health in serious jeopardy or cause a serious dysfunction or impairment of a body organ or part. The Fund or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care.

Section 1.21. The term "Employee" or "Participant" means each person who meets the eligibility rules in Sections 2.01 or 2.02.

Section 1.22. The term "Enrollment" means the process of completing and submitting an enrollment form indicating that coverage by the Plan is requested by the Participant. To enroll in the Plan, a person must apply in writing on a form prescribed by the Board and submit documentation as required by the Board. See Section 2.09.

Section 1.23. The terms "Experimental" or "Investigational" mean a drug or device, medical treatment or procedure, if:

a) The drug or device cannot be lawfully marketed without approval from the United States Food and Drug Administration and if approval for marketing has not been given at the time the drug or device is furnished; or

b) The drug, device, medical treatment or procedure, or the Patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body servicing a similar function, or if federal law requires such review or approval; or

c) "Reliable Evidence" shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

d) "Reliable Evidence" shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, "Reliable Evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Section 1.24. The term "Federal Medicare" means the benefits provided under Title XVIII of the Social Security Act of 1965 and subsequent amendments.

Section 1.25. The term "First Day of Disability" means the date the Participant began receiving Workers' Compensation Benefits, or on the claim effective date established by State Disability Insurance. For a Participant who lives in a state that does not provide State Disability Insurance benefits or who is not receiving Workers' Compensation Benefits, the First Day of Disability is the date he/she became Disabled as certified by the attending Physician.

Section 1.26. The term "Fund" means the Carpenters Health and Welfare Trust Fund for California.

Section 1.27. The term "Group Plan" means any plan providing benefits of the type provided by this Plan which is supported wholly or in part by employer payments.

Section 1.28. The term "Home Health Agency" means a home health care provider which is licensed according to state or local laws to provide skilled nursing and other services on a visiting basis in the Eligible Individual's home, and is recognized as a provider under Federal Medicare.

Section 1.29. The term "Hospice" means a health care facility or service providing medical care and support services, such as counseling, to terminally ill persons and their families.

Section 1.30. The term "Hospital" means any acute care hospital which is licensed under any applicable state statute and must provide: (a) 24-hour inpatient care, and (b) the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. A Hospital may include facilities for mental, nervous and/or chemical dependency treatment that are licensed and operated according to state law. The requirement that a Hospital must provide surgical, anesthesia and/or radiology services does not apply to facilities for mental, nervous and/or chemical dependency treatment. A hospital is subject to all the other limitations and exclusions described in these Rules and Regulations, including but not limited to Section 8.01.cc.

Section 1.31. The term "Hour Bank" means the account established for an Active Participant to which hours are credited if contributions are made by Contributing Employers to the Fund with respect to those hours.

Section 1.32. The term "Illness(es)" means a bodily disorder, infection or disease and all related symptoms and recurrent conditions resulting from the same causes.

Section 1.33. The term "Injury(ies)" means physical harm sustained as the direct result of an accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Section 1.34. The term "Licensed Pharmacist" means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Section 1.35. The term "Limiting Age" means the age at which a child loses eligibility status as defined in Section 1.15.b.

Section 1.36. The term "Medically Necessary," with respect to services and supplies received for treatment of an Illness or Injury, and for the purpose of determining eligibility for Plan benefits, means those services or supplies determined to be:

a. Appropriate and necessary for the symptoms, diagnosis or treatment of the Illness or Injury;

b. Provided for the diagnosis or direct care and treatment of the Illness or Injury;

c. Within standards of good medical practice within the organized medical community;

d. Not primarily for the personal comfort or convenience of the Patient, the Patient's family, any person who cares for the Patient, any Physician or other health care practitioner, or any Hospital or specialized health care facility. The fact that a Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered Medically Necessary for the medical coverage provided by the Plan; and

e. The most appropriate supply or level of service that can safely be provided. For Hospital confinement, this means that acute care as a bed patient is needed due to the kind of services the Patient is receiving or the severity of the Patient's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Section 1.37. The term "Non-Contract Hospital" means a Hospital which does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.38. The term "Non-Contract Facility" means a health care or substance abuse treatment facility that does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.39. The term "Non-Contract Physician" or "Non-Contract Provider" means a Physician or other health care provider that does not have a contract in effect with the Fund's Preferred Provider Organization.

Section 1.40. The term "Non-Qualifying Employment" means work of the type covered by a collective bargaining

agreement with the Union that is performed for a non-Contributing Employer, or work of a type not covered by the terms of a collective bargaining agreement that is reported by a Contributing Employer.

Section 1.41. The term "Orthodontist" means a Dentist whose practice is limited to orthodontics.

Section 1.42. The term "Participant" means each Employee who meets the eligibility rules set forth in Sections 2.01 and 2.02.

Section 1.43. The term "Patient" means that Eligible Individual who is receiving medical treatment, services, or supplies covered by the Plan.

Section 1.44. The term "Physician" means a physician or surgeon (M.D.), an Osteopath (D.O.), or a Dentist (D.D.S. or D.M.D.) licensed to practice medicine or dentistry in the state in which he or she practices.

Section 1.45. The term "Plan" means the Rules and Regulations of the Carpenters Health and Welfare Trust Fund for California for Plan A, Plan R, Plan B and Flat Rate Plan Active Participants including any amendments.

Section 1.46. The term "Plan Year" means September 1 of any year to August 31 of the succeeding year.

Section 1.47. The term "Podiatrist" means a health care provider who specializes in the disease, Injury and surgery to the feet and who is licensed as a Doctor of Podiatric Medicine (DPM) in the state in which services are performed.

Section 1.48. The term "Pre-Admission Review" and "Pre-Admission Certification" means the process whereby the Professional Review Organization (PRO) determines the Medical Necessity of an Eligible Individual's confinement to a Hospital, and if Medically Necessary, the number of pre-authorized Hospital days eligible for unreduced benefit coverage according to the terms of the Plan, *prior* to the Hospital confinement actually occurring.

Section 1.49. The term "Preferred Provider Organization" (PPO) and "Contract Provider Organization" means the entity under contract with the Fund that is responsible for negotiating contracts with Hospitals, Physicians, facilities and other health care providers who agree to provide hospitalization and medical services to Eligible Individuals on the basis of negotiated rates.

Section 1.50. The term "Prepaid Medical Plan" means a Health Maintenance Organization with which the Fund has entered into an agreement to provide health benefits to Eligible Individuals who elect to be covered under that Prepaid Medical Plan.

Section 1.51. The term "Professional Review Organization (PRO)" or "Review Organization" means an organization under contract to the Fund, which is responsible for determining whether the confinement of an Eligible Individual in a Hospital is Medically Necessary. The PRO determines the number of Medically Necessary days for the confinement, the sole purpose of which is to determine whether the Eligible Individual is to receive unreduced benefit coverage according to the terms of the Plan.

Section 1.52. The term "Retired Employee" means a person receiving a pension from the Carpenters Pension Trust Fund for Northern California, or from a related plan, and who meets all other eligibility requirements of the Rules and Regulations for Retirees.

Section 1.53. The term "Skilled Nursing Facility" means an institution as defined in Section 186(j) of the Social Security Act.

Section 1.54. The term "Spouse", wherever it appears in this Plan, will mean the legal spouse, or qualified Domestic Partner of the Participant.

Section 1.55. The term "Stakeholder" means each person who is an owner, partner, shareholder, member of the board of directors of a corporation, officer of an individual employer, superintendent above the rank of foreman or general foreman, or other individual who is in any other way interested in the profits of the employer– other than hourly wages earned or paid pursuant to a collective bargaining agreement.

Section 1.56. The term "State Disability Insurance Benefits" means benefits payable in accordance with the California Unemployment Insurance code including any regulations, or benefits payable in accordance with similar statutes in any other state providing temporary disability benefits.

Section 1.57. For "Temporarily Disabled" please see "Disabled" or "Disability."

Section 1.58. The term "Trust Agreement" means the Trust Agreement establishing the Carpenters Health and Welfare Trust Fund for California dated March 4, 1953, including any amendment, extension or renewal of that Agreement.

Section 1.59. The term "Union" means the Carpenters 46 Northern California Counties Conference Board or one of its affiliated unions.

Section 1.60. The term "Utilization Review (UR) Program" means a program whereby an Eligible Individual who is scheduled for confinement in a Hospital on a non-emergency basis must obtain Pre-Admission Review and Concurrent Review from the Professional Review Organization (PRO) as to the Medical Necessity of that confinement in order to receive unreduced benefit coverage. For emergency confinements, the review must be obtained retrospectively.

Section 1.61. The term "Workers' Compensation Benefits" means temporary disability benefits under a Workers' Compensation Law.

ARTICLE 2. ELIGIBILITY FOR BENEFITS

Section 2.01. Establishing Eligibility

a. An Employee of one or more Contributing Employers with respect to whose work contributions are required to be made to the Fund by a collective bargaining agreement or a Subscriber's Agreement, will become eligible as follows:

(1) **For Plan A**, on the first day of the second calendar month following a period of not more than 6 consecutive calendar months during which he/she worked at least 400 hours for one or more Contributing Employers.

(2) **For Plan B**, on the first day of the second calendar month following a period of not more than 3 consecutive calendar months during which he/she worked at least 280 hours for one or more Contributing Employers.

(3) **For Plan R**, on the first day of the second calendar month following the month in which he/she worked at least 110 hours for a Contributing Employer. Plan R Participants are not entitled to Life Insurance or Accidental Death and Dismemberment benefits.

(4) **Flat Rate Employees** who are on the payroll of their Contributing Employer on the effective date of the Employer's participation in the Plan will become eligible for coverage on that date. Salaried Flat Rate Employees, who are hired after the employer's effective date of participation in the Flat Rate Plan, shall become eligible for coverage on the first day of the month immediately following the date of hire, provided appropriate contributions are remitted. Non-salaried Flat Rate Employees, who are hired after the employer's effective date of participation in the Flat Rate Plan, shall become eligible for coverage on the first day of the fourth month following their date of hire provided appropriate contributions are remitted. For purposes of this Section, a "Flat Rate Employee" is any person who is employed by a Contributing Employer who agrees to a Subscriber Agreement and performs a type of work not covered by any union contract which requires participation in another Health and Welfare plan, who is employed not less than a minimum of 17.5 hours per week by the Contributing Employer, and who is performing work within the 46 Northern California Counties. Flat Rate Employees are not eligible for Weekly Disability benefits.

b. **Dependents.** A person who is a Dependent of an Active Participant will be eligible for the Fund's applicable Indemnity Medical Plan benefits on the date the Participant becomes eligible or on the date the person becomes a Dependent, whichever is later, subject to the Fund's receipt of an enrollment form with all required information. A Dependent's eligibility may be deferred or subject to termination if the Participant fails to provide to the Fund all of the information regarding the Dependent that is required to be provided by federal law. Following receipt of Enrollment documents to add a Domestic Partner (including, if applicable, children of a Domestic Partner) to the Plan, and provided the Participant meets eligibility requirements, Domestic Partner (and, if applicable, children of a domestic partner) eligibility will begin on the first of the second month following the month of Enrollment.

c. Eligibility will be granted only to the extent that contributions have been received by the Fund from Contributing Employers. The Fund assumes that a Participant's hours and contributions are accurate unless the Participant challenges the accuracy of a quarterly statement within one year of receipt of that statement. Participants should retain check stubs or statements as a basis for checking the accuracy of their Health and Welfare eligibility. If the hours do not agree with the hours to which a Participant believes he/she is entitled, the Participant should ask the Fund office to review the contribution records. In order to file a claim for under-reported hours, a Participant must provide proof that hours reported to the Fund Office are less than the hours he/she worked in covered employment for which Health and Welfare contributions were required. The Participant must retain payroll check stubs, which will be required to investigate a claim of under-reporting of hours by the Contributing Employer. Check stub evidence must include the names of Contributing Employers for whom the Participant worked, the dates of work, and wages paid. Written requests for review must be received within one year of the date of receipt of the Participant's combined quarterly statement.

d. A Stakeholder shall be granted eligibility only if all contributions due on behalf of all hours for all employees are current and all delinquencies are resolved. Hours reported on behalf of a Stakeholder must equal or exceed an average of 145 hours during the three most current work months.

Section 2.02. Maintaining Continued Eligibility

a. **Maintaining Continued Eligibility – Plan A and Plan B**

(1) Hour Bank Deductions: Once eligibility is established, a Participant's eligibility will continue during subsequent months for which the appropriate deduction is made from the Hour Bank. 100 hours are deducted from the Active Participant's Hour Bank for each month of continued eligibility. A lag month will exist between the month in which the hours are worked and the month of eligibility provided by those hours; therefore, hours worked in a month provide eligibility for the second month following the month in which the hours were worked.

(2) The maximum hours in a Participant's Hour Bank after deducting 100 hours for the current month's eligibility may not exceed:

(a) For Plan A: 600 hours

(b) For Plan B: 300 hours

b. **Maintaining Continued Eligibility – Plan R and Flat Rate Plan**

(1) **Plan R.** Once eligibility is established, a Plan R Participant's eligibility will continue for subsequent months provided he/she works at least 110 hours each month, and his/her Employer continues to make the required contribution to the Fund on his or her behalf. A lag month will exist between the month in which the hours are worked and the month of eligibility provided by those hours; therefore, hours worked in a month provide eligibility for the second month following the month in which the hours were worked.

(2) **Flat Rate Plan.** Once eligibility is established, a Flat Rate Participant's eligibility will continue provided that he/she continues to work a minimum of 17.5 hours per week and his/her Contributing Employer continues to make the required contributions to the Fund on his or her behalf. There is no lag month for Flat Rate Plan Participants.

(3) There is no Hour Bank for Plan R or Flat Rate Plan Participants.

Section 2.03. Termination and Reinstatement of Eligibility, Cancellation of Hour Bank

a. **Termination of Participants' Eligibility.** Except as provided in Subsection e. below, a Participant's eligibility will terminate on the earliest of the following dates:

(1) **For Plan A and Plan B Participants**, the first day of the month following exhaustion of coverage provided by the Hour Bank;

(2) **For Plan R Participants**, the last day of the month following the month during which the Participant did not work a minimum of 110 hours for a Contributing Employer;

(3) **For Flat Rate Plan Participants**, the last day of the month following the month in which the Participant terminates employment with a Contributing Employer;

(4) The first day of the month following the date the Fund Office is notified of his or her entry into Non-Qualifying Employment; or

(5) The first day of the month in which he/she becomes eligible for coverage as a Retired Employee

b. **Termination of Dependents' Eligibility.** The eligibility of a Dependent of a Participant will terminate on the earlier of the following dates:

(1) On the date the Participant's eligibility terminates or, in the event of the death of the Participant, on the date his or her eligibility would have terminated but for this death; or

(2) On the date he or she no longer qualifies as a Dependent, except that eligibility for Dependent natural children, stepchildren and legally adopted children will terminate at the end of the moth in which the Dependent turns age 26.

c. A Dependent child 19 years of age or older whose eligibility is based on student status will continue to be eligible during a Medically Necessary leave of absence from school, subject to the following:

(1) Eligibility will continue for up to 12 months or until eligibility would otherwise terminate under the Fund's eligibility rules, whichever comes first.

(2) Eligibility will terminate before 12 months on the date the Medical Necessity for the leave no longer exists.

(3) The Dependent or Participant must submit documentation to the Fund Office, including a Physician's certification of the medical necessity for the leave. The certification form must be submitted to the Fund Office at least 30 days prior to the medical leave of absence if it is foreseeable, or 30 days after the start of the leave of absence in any other case.

(4) If eligibility is extended under this provision for a child who is no longer eligible for tax-free health coverage, the Participant parent of the Dependent may be required to certify in writing to the Fund as to the child's tax status.

d. **Termination of Eligibility for Stakeholders.** In addition to Subsection f. below, the eligibility of a Stakeholder will terminate on the earlier of the following dates:

(1) If performing work covered under a collective bargaining agreement, eligibility will end on the first day of the second calendar month that follows a period of not more than three consecutive calendar months during which she/he averaged less than 145 work hours per month.

(2) The first day of the month following the employer's failure to resolve delinquencies or remit all contributions due on behalf of all hours reported for all employees.

(3) If following a period of having hours reported by an individual employer as a Stakeholder, the employer stops reporting hours for such individual who remains in the employ of the employer in any capacity, the first day of the second calendar month.

e. **Reinstatement of Eligibility**

(1) **Plan A:**

(a) If a **Plan A Participant's** eligibility has terminated, his/her eligibility will be reinstated on the first day of the second calendar month following the month in which his/her Hour Bank balance, when combined with the work hours reported during the next 2 months following termination of eligibility, equals at least 100 hours.

(b) If a **Plan A Participant** is Disabled and has exhausted any coverage provided through Disability Extension, as described in Section 2.05, his/her eligibility will be reinstated on the first day of the second calendar month after his/her Hour Bank shows a total of at least 100 hours provided those hours were worked within the 4 month period immediately following the month in which he or she is no longer certified Disabled by a Physician.

(c) Any **Plan A Participant** who fails to reinstate eligibility in accordance with paragraph (1) will again become eligible upon meeting the requirements of Subsection 2.01.a.(1).

(2) **Plan B.** If a Plan B Participant's eligibility has terminated, his/her eligibility will be reinstated in accordance with Subsection 2.01.a.(2).

(3) **Plan R.** If a Plan R Participant's eligibility has terminated, his/her eligibility will be reinstated in accordance with Subsection 2.01.a.(3).

(4) **Flat Rate Plan.** If a Flat Rate Participant's eligibility has terminated, his/her eligibility will be reinstated in accordance with Subsection 2.01.a.(4).

f. **Cancellation of Hour Bank – Plans A and B.** An Active Plan A or Plan B Participant will have his/her Hour Bank immediately reduced to zero when any of the following circumstances occur:

(1) The Participant fails to report to the Fund the existence of coverage under another Group Plan for the Participant or his/her Dependents, or both; or

(2) The Participant permits a Contributing Employer to contribute to the Fund on the basis of fewer hours than he/she actually worked for that Contributing Employer (except as provided by the collective bargaining agreement); or

(3) The Participant performs a type of work that is covered by a collective bargaining agreement requiring contributions to the Fund for an employer who is not a Contributing Employer; or

(4) Following 4 consecutive months in which hours are reported for the Participant for which the Contributing Employer fails to remit the required contributions; or

(5) For a Participant who is eligible to participate as a Retired Employee under the Fund's Rules and Regulations for Retirees, the first day of the fourth month following the date of retirement regardless of whether the Participant elects to enroll for coverage as a Retired Employee and regardless of whether the Participant delays enrolling in that coverage because he or she has other health coverage.

(6) For a Stakeholder:

(a) If performing work covered under a Collective Bargaining Agreement, the first day of the second calendar month that follows a period of not more than three consecutive calendar months during which she/he averaged less than 145 work hours per month.

(b) The first day of the month following the employer's failure to resolve delinquencies or remit all contributions due on behalf of all hours reported for all employees.

(c) If following a period when previously reported as a Stakeholder, the employer stops reporting hours for such individual who remains in the employ of the employer in any capacity, the first day of the second calendar month.

Section 2.04. Military Service

Participants who enter military service with the Uniformed Services of the United States may continue their eligibility under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), provided they were eligible under the Plan when the military service began. The term "Uniformed Services" means the Armed Services (including the Coast Guard), 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 Service, and any other category of persons designated by the President in time of war or emergency.

a. Participants whose period of military service is less than 31 days will have their eligibility continued during the period of military service with no self-payment.

b. Participants whose period of military service is 31 days or more may continue their eligibility by self-payment for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). During the first 18 months of continuation coverage, the Participant will have all COBRA rights, such as the right to elect additional months of coverage in the event of a second Qualifying Event or a Social Security disability determination. These rights do not apply during the last 6 months of the 24-month period. The USERRA continuation coverage is an alternative to COBRA Continuation coverage. Participants may choose either 24 months of USERRA continuation coverage or 18 months of COBRA continuation coverage. The continuation coverage will run simultaneously, not consecutively.

c. Plan A and Plan B Participants may elect to use their Hour Bank to continue Fund coverage during military service and will be entitled to eligibility based on the hours in the frozen Hour Bank at the end of their military service, provided they return to work for a Contributing Employer in the 46 Northern California counties and notify the Fund in writing within the time frames outlined in Subsection 2.04(e) below.

d. Participants must notify the Fund in writing of their entry in to military service as soon as possible, but no later than 60 days after their military service begins. The notice must indicate whether the Participant elects to:

   (1) Self-pay to continue Fund coverage;

   (2) Not be covered by the Fund; or

   (3) Use accumulated Hour Bank eligibility during military service

e. A Participant whose eligibility has terminated for any reason during military service will have his/her eligibility reinstated upon return to work with a Contributing Employer in the 46 Northern California counties, provided he/she returns to such employment and notifies the Fund in writing within:

   (1) 90 days after separation from military service if the service lasted more than 180 days; or

   (2) 14 days after separation from military service if the service lasted 31 to 180 days.

   Eligibility will be reinstated without exclusion or waiting period, except that the Fund will not cover any Illness or Injury that the Department of Veteran Affairs has determined to be in connection with the Participant's military service.

(f) Notwithstanding Sections (a) through (e) above, any Participant who is in the military reserves of the Uniformed Services of the United States and who is called up to active military duty (other than a temporary tour of duty of 30 days or less) will have his/her Hour Bank credited with 100 hours on the first day of each month for the duration of that tour of duty, provided he/she is eligible under the Plan on the date he/she reports for active military duty.

Section 2.05. Disability Extension – Plans A, B and R Only

a. An eligible **Plan A, B or R Participant** who is unable to work for a Contributing Employer as a result of a temporary Disability and who is receiving either Workers' Compensation Benefits or State Disability Insurance benefits, will have added to his/her Hour Bank sufficient hours of disability credit to extend existing eligibility for an additional month not to exceed a maximum of **9 months disability extension for Plan A**, or **4 months disability extension for Plan B and Plan R**, within the most recent 24 month period, subject to the following provisions:

(1) The Participant must have earned eligibility, based on work hours or, for Plans A and B, an hour bank deduction from bank hours accrued as a result of work hours (not disability extension), for the month in which he or she became Disabled and for the next following month.

(2) The participant must have worked for a Contributing Employer at least 1 day within the 30-day period preceding the First Day of Disability, and

(3) The Participant must have been eligible under the Plan for a minimum of 12 calendar months, based on work hours or an hour bank deduction from bank hours accrued as a result of work hours (not a disability extension), within the 24 calendar months immediately preceding the First Day of Disability.

b. **Exclusions and Limitations.** Benefits provided by this Section will not be provided for the following:

(1) A Participant who has not been eligible under the Plan in a minimum of 12 calendar months, based on work hours or an hour bank deduction from bank hours accrued as a result of work hours (not a disability extension), within the 24 calendar months immediately preceding the First Day of Disability, as defined in Section 1.25.

(2) Any Period of Disability for which evidence of receipt of Workers' Compensation Benefits or State Disability Insurance Benefits has not been furnished to the Fund.

(3) A Disability for which the Plan has not received notice of claim within 12 months of the First Day of Disability.

(4) Any Period of Disability which begins while the Participant is receiving Continuation Coverage under COBRA, as described in Section 2.07.

(5) A Participant who has not worked for a Contributing Employer at least one day within the 30-day period preceding the First Day of Disability, as defined in Section 1.25.

(6) Any Participant who is a Stakeholder.

c. A Participant who does not reside in a state that provides State Disability Insurance Benefits is also eligible for the benefit stated in this Subsection if he/she provides the Plan with written certification from a Physician approved by the Plan that he/she is Disabled as defined by the Plan.

d. To qualify for the Disability extension, the Disabled Participant must file an application with the Fund within 12 months of the First Day of Disability.

Section 2.06. Special Conditions for Retired Employees Who Engage in Active Employment.

a. A Participant who is receiving benefit payments from the Carpenters Pension Trust Fund for Northern California, who engages in a type of work beginning June 1, 2009 that requires contributions to this Fund but does not result in the suspension of benefit payments from the Carpenters Pension Trust Fund for Northern California will not establish eligibility under this Plan.

However, if the Retired Employee works enough consecutive hours such that, in the absence of this rule, he/she would normally qualify for eligibility as an active Employee, 50% of the health and welfare contributions remitted to this Plan on the Retired Employee's behalf will be used to offset his/her self-pay contributions for Retiree health coverage. Such offset will only be granted for 50% of contributions on up to a maximum of 480 hours in a calendar year.

b. If the individual is not an eligible Retired Employee in the Retiree Health and Welfare Plan, or if the hours worked are less than the number required to earn eligibility under this Plan in the absence of this rule, no health and welfare contributions will be credited on the individual's behalf.

c. A Retiree in the Carpenters Pension Trust Fund for Northern California who has his or her pension suspended may establish and maintain eligibility as an active Employee under this Plan in accordance with Subsections 2.01.a. through d.

d. On or after January 1, 2010, a Participant who has not separated from service but has begun a mandatory commencement of Pension payments from the Carpenters Pension Trust Fund for Northern California by virtue of having reached the Required Beginning Date may maintain eligibility as an Active Employee under this Plan in accordance with Subsections 2.01.a. through d.

Section 2.07. Continuation Coverage Under COBRA

The health care continuation coverage provisions of the Employee Retirement Income Security Act, Sections 601 et seq., as amended (COBRA) require that under specific circumstances when coverage terminates, certain health plan benefits available to Eligible Individuals must be offered for extension through self-payment. To the extent that COBRA applies to any Eligible Individual under this Plan, these required benefits will be offered in accordance with this Section.

a. **General.** Participants and their Dependents who lose eligibility under the Plan may continue Plan coverage subject to the terms of this Section. This Section is intended to comply with the health care continuation provisions of COBRA and any of its regulations. Those provisions are incorporated by reference into the Plan and will be controlling in the event of any conflict between those provisions and the terms of this Section. The Continuation Coverage provisions described in this Section do not apply to Domestic Partners or children of Domestic Partners, or to a Stakeholder of an Employer that reported hours on his/her behalf.

b. **Continuation Coverage.** Participants and their Dependents whose eligibility terminates may continue coverage (except Life Insurance, Accidental Death and Dismemberment benefits and Supplemental Weekly Disability benefits), under COBRA upon the occurrence of a "Qualifying Event." A "Qualifying Event" is defined as any of the following:

   (1) The Participant's Employer(s) reports less than the minimum required hours as shown in Sections 2.02.a. or 2.02.b. to the Fund on the Participant's behalf for any month;

   (2) Termination of the Participant's employment (for Flat Rate Plan);

   (3) The Participant's death;

   (4) Divorce of the Participant from his or her dependent Spouse;

   (5) Cessation of a Dependent child's dependent status.

c. **Qualified Beneficiary.** A Qualified Beneficiary as defined under COBRA is an individual who loses coverage under any of the above referenced Qualifying Events. A child born to or placed for adoption with a Participant during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

d. **Duration of Coverage.**

   (1) A Qualified Beneficiary whose coverage would otherwise terminate because of a Qualifying Event may elect continuation coverage for up to 18 months from the date of the Qualifying Event. The 18-month period in the preceding sentence will expand to a maximum of 36 months from the date of the Qualifying Event if a second Qualifying Event (other than a Qualifying Event described in paragraph (1) or (2) of Section 2.07.b. occurs with respect to that Qualified Beneficiary during the original 18-month period and while the Qualified Beneficiary is covered under the Plan.

   (2) Any months of extended eligibility resulting from hours remaining in a Participant's Hour Bank (for Plans A and B) will count toward the 18-month COBRA Continuation Coverage period and will subsidize 100% of the cost of the Qualified Beneficiary's COBRA Continuation Coverage for those months.

   (3) If coverage is terminated due to a Qualifying Event described in Section 2.07.b.(1) or (2), the 18-month period may be extended up to a total of 29 months for any Qualified Beneficiary who is determined by Social Security to be totally disabled as of the date of the Qualifying Event, or within 60 days thereafter. Other Qualified Beneficiaries in the disabled Qualified Beneficiary's family are also eligible for the 29-month extended coverage period. To qualify for the additional 11 months, a Qualified Beneficiary must report the Social Security disability determination to the Fund Office in writing before the original 18-month continuation coverage period expires.

   (4) If the Qualifying Event described in Section 2.07.b.(1) or (2) occurs less than 18 months *after* the date the Participant becomes entitled to Medicare (Part A, Part B or both), the maximum period of continuation coverage for the Dependents of the Participant will be 36 months from the date of the Participant's Medicare entitlement.

(5) Medicare entitlement is not a Qualifying Event under the Plan. Medicare entitlement *following* a Participant's termination of employment or reduction in hours will not extend a Dependent Qualified Beneficiary's COBRA coverage beyond the 18-month period allowed for the Qualifying Event described in Sections 2.07.b.(1) and (2).

(6) A Qualified Beneficiary whose coverage would otherwise terminate because of a Qualifying Event described in paragraphs (3), (4) and (5) of Section 2.07.b., may elect continuation coverage for up to 36 months from the date of the Qualifying Event.

e. **Termination of Continuation Coverage.** Notwithstanding the maximum duration of coverage described in Section 2.07.d, a Qualified Beneficiary's continuation coverage will end on the earliest of the following dates on which:

(1) The Participant's Employer ceases to provide group health coverage to any of its employees;

(2) The premium described in Section 2.07.g. is not timely paid;

(3) The Qualified Beneficiary becomes covered under any other Group Plan after the Qualifying Event (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of the Qualified Beneficiary;

(4) The Qualified Beneficiary becomes entitled to Medicare benefits after the date he or she elected COBRA Continuation Coverage. Entitled to Medicare benefits means being enrolled in either Part A or Part B of Medicare, whichever occurs earlier;

(5) The Participant or Dependent has continued coverage for additional months due to a disability and there has been a final determination by Social Security that the individual is no longer disabled.

f. **Types of Benefits Provided.** A Qualified Beneficiary will be provided health coverage under the Plan which is identical to the health coverage that is provided to other Eligible Individuals who have not experienced a Qualifying Event. A Qualified Beneficiary will have the option of taking "Core Coverage" only instead of full coverage. "Core Coverage" refers to the health benefits the Qualified Beneficiary was receiving immediately before the Qualifying Event, *except* vision, dental and life benefits.

g. **Premiums**

(1) A premium for continuation coverage will be charged to Qualified Beneficiaries in amounts established by the Board of Trustees. This premium may be payable in monthly installments. However, at the discretion of the Board of Trustees, and as may be amended from time to time, premiums are not charged for any portion of the COBRA period during which the Trust Fund extends coverage based upon the Hour Bank rules of the Plan for Plan A and Plan B Participants as described in Section 2.02.a.

(2) Any premium due for coverage during the period before the election was made must be paid within 45 days of the date the Qualified Beneficiary elects continuation coverage. For a Plan A Qualified Beneficiary who elects COBRA continuation coverage while running out his/her Hour Bank, initial premium payment must be paid within 45 days of the date the Qualified Beneficiary elects continuation coverage, or the first day of the first month after the Hour Bank is exhausted, whichever is later.

(3) After the initial premium payment, monthly premium payments must be made no later than the first day of the month for which continuation coverage is elected. There will be a grace period of 30 days to pay the monthly premium payments. If payment of the amount due is not made by the end of the applicable grace period, COBRA Continuation Coverage will terminate. The Board of Trustees may extend the premium payment due date.

h. **Notice Requirements for Qualified Beneficiaries**

(1) The Qualified Beneficiary is responsible for providing the Fund Office with timely written notice of any of the following events:

(a) The divorce of a Participant from his or her spouse.

(b) A child losing dependent status under the Plan.

(c) If a second Qualifying Event occurs after a Qualified Beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months.

In the case of any of the events described in Subsections (a), (b) and (c) above, the Qualified Beneficiary must notify the Fund Office in writing no later than 60 days after the date of the qualifying event.

(d) When a Qualified Beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled, the Qualified Beneficiary must provide written notice to the Fund Office of the disability determination before the end of the initial 18-month continuation coverage period.

(e) When the Social Security Administration determines that a Qualified Beneficiary is no longer disabled, written notice must be provided to the Fund Office no later than 30 days after the date of the determination by the Social Security Administration that the person is no longer disabled.

(2) The written notice must contain the following information: name of qualified beneficiary, Participant's name and identification number, the qualifying event for which notice is being given, date of the qualifying event, copy of the final marital dissolution if the event is a divorce.

(3) Notice may be provided by the Participant, Qualified Beneficiary with respect to the qualifying event, or any representative acting on behalf of the Participant or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same qualifying event.

(4) Failure to provide the Fund Office with written notice of the occurrences described in Subsection (1) above, and within the required timeframes, will prevent the individual from obtaining or extending COBRA continuation coverage.

i. **Notice Requirements for Employers and the Plan**

(1) If the Qualifying Event is the death of the Participant, the employer must notify the Fund Office in writing of the Qualifying Event within 30 days after the Qualifying Event.

(2) If the Qualifying Event is a reduction in hours, the determination that a Participant's employer(s) has reported less than the minimum required hours referenced in Section 2.07.b.(1) on the Participant's behalf will be made by the Fund Office. If the Qualifying Event is termination of employment referenced in Section 2.07.b.(2), the employer must notify the Fund Office in writing of Qualifying Event within 30 days after the Qualifying Event.

(3) No later than 60 days after the date on which the Fund Office receives written notification from the Qualified Beneficiary or employer, or after the Fund Office has determined that less than the minimum required hours have been reported by the employer, the Plan will send a written notice to the Qualified Beneficiary affected by the Qualifying Event of his or her rights to continuation coverage.

Notwithstanding the immediately preceding paragraph, the Plan's written notification to a Qualified Beneficiary who is a Dependent spouse will be treated as notification to all other Qualified Beneficiaries residing with that person at the time the notification is made.

j. **Election Procedure**

(1) A Qualified Beneficiary must elect continuation coverage within 60 days after the later of:

(a) The date eligibility under the Plan would otherwise terminate; or

(b) The date of the notice from the Fund Office notifying the Qualified Beneficiary of his or her right to COBRA continuation coverage.

(2) Any election by a Qualified Beneficiary who is a Participant or Dependent Spouse with respect to continuation coverage for any other Qualified Beneficiary who would lose coverage under the Rules and Regulations of the Plan as a result of the Qualifying Event will be binding. However, each individual who is a Qualified Beneficiary with respect to the qualifying event has an independent right to elect COBRA coverage. The failure to elect continuation coverage by a Participant or Dependent Spouse will result in any other Qualified Beneficiary being given a 60-day period to elect or reject coverage.

k. **Addition of New Dependents**

(1) If, while enrolled for COBRA Continuation Coverage, a Qualified Beneficiary marries, has a newborn child, has a child placed for adoption or assumes legal guardianship of a child, he/she may enroll the new spouse or child for coverage for the balance of the period of COBRA Continuation Coverage by doing so within 30 days after the birth, marriage, placement for adoption or assumption of legal guardianship. Adding a child or spouse may cause an increase in the amount that must be paid for COBRA Continuation Coverage.

(2) Any Qualified Beneficiary may add a new spouse or child to his or her COBRA Continuation Coverage. The only newly added family members who have the rights of a Qualified Beneficiary, such as the right to stay on COBRA coverage longer in the event of a second Qualifying Event, are the natural or adopted children of the former Participant or children for whom the former Participant is legal guardian.

l. **Additional COBRA Election Period in Cases of Eligibility for Benefits Under the Trade Act Amendments of 2002**

A Participant who is certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act Amendments of 2002 may be eligible for a new opportunity to elect COBRA. If the participant and/or Dependents did not elect COBRA during their election period, but are later certified by the DOL for Trade Act benefits or receive a pension managed by the Pension Benefit Guaranty Corporation (PBGC), they may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which they were certified. However, in no event would this benefit allow a person to elect COBRA later than 6 months after his or her coverage ended under the Plan.

Section 2.08. Continuation Coverage for Domestic Partners and Children of Domestic Partners

Eligible Domestic Partners of Participants and eligible children of those Domestic Partners who lose eligibility under the Plan may continue Plan coverage through self-payment under the terms of this Section.

a. **Continuation Coverage.** The Domestic Partner and child(ren) of the Domestic Partner who lose eligibility under the Plan may continue Plan coverage (except Life Insurance and Accidental Death and Dismemberment benefits) when eligibility is lost due to any of the following reasons:

(1) The Participant's Employer(s) reports less than the minimum required hours as shown in Sections 2.02.a. or 2.02.b. to the Fund on the Participant's behalf for any month, or termination of the Participant's employment;

(2) The Participant's death;

(3) Termination of the Domestic Partner relationship with the Participant;

(4) Cessation of a Dependent child's dependent status under the Plan.

b. **Premiums.** A premium for continuation coverage will be charged to the Domestic Partner and/or Dependent child in amounts established by the Board of Trustees. This premium may be payable in monthly installments. However, at the discretion of the Board of Trustees, premiums are not charged for any portion of the continuation coverage period during which the Trust Fund extends coverage based on the Hour Bank rules of the Plan for Plan A and Plan B Participants as described in Section 2.02.a.

c. **Duration of Continuation Coverage.** In the case of the Participant's reduction in hours or termination of employment, coverage may be continued on a self-payment basis for up to 18 months from the date of the event that resulted in the loss of eligibility. In all other circumstances described in Section 2.08.a., coverage may be continued for up to 36 months from the date of the event which resulted in loss of eligibility.

d. **Termination of Continuation Coverage.** Continuation coverage will be terminated before the end of the 18 or 36-month period upon the occurrence of any of the following events:

(1) The required premium payment for continuation coverage is not paid when due;

(2) The Participant's Employer ceases to provide group health coverage to any of its employees;

(3) The Domestic Partner or Dependent child becomes covered under any other Group Plan after the Qualifying Event (as an employee or otherwise) or becomes entitled to Medicare coverage.

e. **Notice Requirements.** All of the notice requirements described in Sections 2.07.h. and 2.07.i. also apply to Domestic Partners and/or children of Domestic Partners.

f. **Election and Notice Procedure.** The Domestic Partner and/or child must elect continuation coverage within 60 days after the later of:

(1) The date eligibility under the Plan would otherwise terminate; or

(2) The date of the notice from the Fund Office notifying the individual of his or her right to continuation coverage.

Section 2.09. Election of Coverage

a. Each Participant who becomes eligible will have the opportunity to elect the Indemnity Medical and Prescription Drug coverage provided directly by the Fund, as described in these Rules and Regulations, or the coverage offered through the Kaiser Foundation Plan. A Participant must live within the service area of the Kaiser Foundation Plan to enroll in that plan and will be limited to Kaiser Foundation Plan's retroactive period. Except as provided under the International Benefit Option described in Subsection f. below, the coverage selected by the Participant will also apply to any eligible Dependents of the Participant.

b. **Changes in Coverage.** Eligible Participants must remain in the plan selected for a minimum of 12 months, unless the Participant moves out of the Kaiser Foundation Plan's service area or a change is approved by the Board of Trustees. Any change in plans will be effective on the first day of the second calendar month following the date the enrollment form is received by the Fund.

c. Participants who elect the Indemnity Medical coverage may decline Vision coverage and all Participants may decline Dental coverage for themselves and their Dependents if they do not want these benefits. There will be no financial reward from the Plan for declining this coverage. Participants who do not tell the Fund Office that they want to decline the coverage will be automatically enrolled in Dental and Vision coverage.

d. **International Benefit Option.** A Participant who has immigrated to the United States of America may have Dependents remaining in his/her native country. Medical and dental claims may be submitted to the Fund on behalf of those Dependents residing outside of the United States with proper documentation as required by the Plan; however, in some cases the infrastructure necessary to submit claims may not exist. Individuals may have the option to purchase health insurance coverage for their Dependents from the government of their native country. A Participant who has purchased this type of Dependent coverage may elect to enroll in this Plan's International Benefit Option.

(1) The International Benefit Option provides Fund indemnity benefits for the Participant only and will reimburse the Participant for the actual payment he/she has made to a foreign government for Dependents' health coverage, up to a maximum of $100 per calendar year for each eligible Dependent, subject to the following conditions:

(2) The Participant must be eligible for Fund benefits at the time he/she makes payment to the foreign government for Dependent health insurance;

(3) The payment is made to purchase health coverage for Dependents who meet this Plan's definition of Dependent as defined in Section 1.15;

(4) The Fund will provide only one reimbursement per eligible Dependent in any consecutive 12-month period;

(5) The Participant must elect coverage for himself or herself under the indemnity medical and prescription drug benefits provided directly by the Fund; and

(6) If a Participant subsequently wants to provide coverage for his/her Dependents in the United States, the Dependents must be enrolled in one of the other benefit options offered by the Fund, in accordance with Subsections 2.09.a. and 2.09.b. Enrollment of Dependents in one of the Fund's other benefit options will terminate eligibility for the reimbursement provided under the International Benefit Option.

Section 2.10. Reciprocity Between Funds

Purpose. Eligibility for benefits is provided under this Section for Participants who would otherwise be ineligible for health and welfare benefits because their hours of employment have been divided between different health and welfare funds. The provisions of this Section are only operative if the United Brotherhood of Carpenters and Joiners of America Master Reciprocal Agreement for Health and Welfare Funds has been adopted by the signatory funds (referred to as Cooperating Funds) in whose jurisdiction the Participant works.

a. **Home Fund.** For purposes of this Section, the term "Home Fund" means:

(1) For Participants who are members of a local union: the Cooperating Fund in which their local union participates by virtue of its collective bargaining agreement with employers; or

(2) Participants who are not members of a local union, or who are primarily employed within the jurisdiction of a local union other than the one of which they are members: the Cooperating Fund in which the Participant has worked the majority of hours in the most recent 5 calendar years.

b. **Outside Fund.** For purposes of this Section, the term "Outside Fund" means any Cooperating Fund under which a Participant works which is not his or her Home Fund.

c. **Contributions.** Contributions for health and welfare required of employers will be made at the rate, at the times, in the manner and at the places required in the collective bargaining agreement covering the geographical area where the Participants actually perform work.

d. **Participant Authorization.** Participants working outside of the area covered by their Home Fund may authorize their Home Fund to request the Outside Fund to transmit to the Home Fund the monies received by the Outside Fund from employers because of his/her employment. By this request the Participant will waive all rights that he or she may have to eligibility for benefits in the Outside Fund. This request and waiver will continue until the Participant has revoked those conditions in writing delivered to his/her Home Fund. The Home Fund will deliver a copy of the written revocation to the Outside Fund.

e. **Transfer of Contributions.** The Home Fund of the Participant will file with the Outside Fund a photocopy of its Participant's waiver and request for transmittal to it of the payments received by the Outside Fund because of the work of the Participant. Each quarter year ending March 31st, June 30th, September 30th and December 31st, the Outside Fund at its expense will transmit to the Home Fund all monies received because of the work of the Participant. The transmittal must be accompanied by an appropriate report. However, no transmittal of payments will be made for a period prior to one calendar year from the date an Outside Fund received a Participant's waiver and request.

f. **Eligibility Credit.** The rules of eligibility of the Cooperating Funds will provide that Participants will receive eligibility credits towards all benefits for work performed for which contributions were made to an Outside Fund and transmitted to their Home Fund. Credits will only be granted to the Participant by his/her Home Fund. In determining the amount to be credited, contributions received by a Home Fund from an Outside Fund will be converted to hours based on the contribution rate in effect at the time with the Home Fund.

g. **Change in Home Fund.** It is recognized that situations will arise where a Participant will, because of good cause, change his/her Home Fund. The following rules will apply when a Participant wishes to change his/her Home Fund from one Cooperating Fund to another Cooperating Fund:

(1) A request must be made in writing to both the existing Home Fund and the Cooperating Fund that the Participant desires to be designated as his/her new Home Fund.

(2) This request must be in a form, and contain any information, that is required by both Cooperating Funds.

(3) The change in Home Fund will be effective when approved by both Cooperating Funds.

ARTICLE 3. INDEMNITY MEDICAL PLAN BENEFITS

The benefits described in this Article are payable for Covered Expenses incurred by an Eligible Individual for Medically Necessary treatment of a non-occupational Illness or Injury and preventive services specifically covered by the Plan. An expense is incurred on the date the Eligible Individual receives the service or supply for which the charge is made. These benefits are subject to the Exclusions, Limitations and Reductions set forth in Article 8 and all provisions of the Plan that may limit benefits or result in benefits not being payable.

Section 3.01. Deductible

The Plan will not begin paying Indemnity Medical Plan benefits until the Eligible Individual or family has satisfied the deductible amount for the calendar year, as specified below for Contract and Non-Contract Providers. Only Covered Expenses are applied to the deductible. Amounts not payable due to failure to comply with the Plan's Utilization Review Program or amounts exceeding any Plan limits on specific benefits are not applied to the deductible.

a. Deductible amount per calendar year for:

(1) Contract Providers – $128 per person, not to exceed $256 per family

(2) Non-Contract Providers – $257 per person, not to exceed $514 per family

b. Any amounts applied to the deductible for Contract Providers will also count toward the Non-Contract Provider deductible, and any amounts applied to the Non-Contract Provider deductible will also count toward the Contract Provider deductible amount.

c. Only amounts that have been applied to an individuals per person deductible will apply to the family deductible amount.

d. Exceptions to Non-Contract Provider Deductible. The deductible for Contract Providers will apply to the Non-Contract Provider services outlined in Subsections 3.02.c.(2) and (3) below.

e. The Deductible does not apply to Mental Health and Chemical Dependency Treatment benefits.

f. The Deductible does not apply to Contract Provider on-line physician visits, provided the charge does not exceed $49 per visit (Effective January 1, 2017).

Section 3.02. Payment

Except as otherwise stated in Subsection c. below, and until the Annual Out of Pocket Maximum described in Section

3.03 is met, all benefits for Covered Expenses are payable as follows, subject to Section 3.01.:

a. **Plan A and Plan R:**

(1) Contract Providers – 90% of the negotiated contract rate

(2) Non-Contract Providers – 70% of the Allowed Charge

b. **Plan B and Flat Rate Plan:**

(1) Contract Providers – 80% of the negotiated contract rate

(2) Non-Contract Providers – 60% of the Allowed Charge

c. **Exceptions to Payment Percentages Specified in Subsections a. and b.:**

(1) Mental Health and Chemical Dependency Treatment. Benefits are payable in accordance with Section 3.07.l.

(2) Contract Provider On-line physician visits. Benefits are payable in accordance with Section 3.06.k. (Effective January 1, 2017).

(3) Exception to Non-Contract Provider Payment **for Plan A and Plan R**:

(a) If a Non-Contract anesthesiologist or emergency room Physician provides services at a Contract Hospital or Contract Facility, the benefit payable is **90%** of the Allowed Charge.

(b) The benefit payable for Non-Contract Provider licensed ambulance service is **90%** of the Allowed Charge.

(c) If the service provided is Medically Necessary and not available from a Contract Provider, the benefit payable is **90%** of the Allowed Charge.

(d) For Emergency Care in a Non-Contract Hospital when the Eligible Individual had no choice in the Hospital used due to the Emergency, the benefit payable is **90%** of Allowed Charges for emergency room services or inpatient services if the Patient was admitted to the Hospital from the emergency room. However, for inpatient confinements, the Plan may require that the Patient transfer to a Contract Hospital upon the advice of a Physician that it is medically safe to transfer the Patient and the acute Emergency period has ended. If the Patient remains in the Non-Contract Hospital after the acute Emergency period, the benefit payable will be **70%** of the Allowed Charge for the period of confinement after the Emergency period has ended.

(4) Exception to Non-Contract Provider Payment **for Plan B and the Flat Rate Plan**:

(a) If a Non-Contract anesthesiologist or emergency room Physician provides services at a Contract Hospital or Contract Facility, the benefit payable is **80%** of the Allowed Charge.

(b) The benefit payable for Non-Contract Provider licensed ambulance service is **80%** of the Allowed Charge.

(c) If the service provided is Medically Necessary and not available from a Contract Provider, the benefit payable is **80%** of the Allowed Charge.

(d) For Emergency Care in a Non-Contract Hospital when the Eligible Individual had no choice in the Hospital used due to the Emergency, the benefit payable is **80%** of Allowed Charges for emergency room services or inpatient services if the Patient was admitted to the Hospital from the emergency room. However, for inpatient confinements, the Plan may require that the Patient transfer to a Contract Hospital upon the advice of a Physician that it is medically safe to transfer the Patient and the acute Emergency period has ended. If the Patient remains in the Non-Contract Hospital after the acute Emergency period, the benefit payable will be **60%** of the Allowed Charge for the period of confinement after the Emergency period has ended.

Section 3.03. Annual Out of Pocket Maximum

Each calendar year, after an Eligible Individual or family incurs the maximum out of pocket cost for Covered Expenses as specified below in Subsection a., the Plan will pay 100% of Covered Expenses incurred during the remainder of that

calendar year. Only Covered Expenses will be applied to the out of pocket maximum. Amounts not payable due to failure to comply with the Plan's pre-authorization requirements or amounts exceeding any Plan benefit limits or maximums will not be applied to the out of pocket maximum.

a. Annual Out of Pocket Maximum for Contract Providers:

   (1) Plan A and Plan R: $1,289 per person, not to exceed $2,578 per family

   (2) Plan B and Flat Rate Plan: $6,445 per person, not to exceed $12,890 per family

b. There is no Annual Out of Pocket Maximum for Non-Contract Provider charges.

c. The following expenses will not count toward the out of pocket maximum and will not be payable at 100% after the out of pocket maximum is reached:

   (1) Amounts applied to the deductible.

   (2) Any amounts exceeding the Plan limits for specific benefits, including the Plan limits for the following benefits: acupuncture, chiropractic services, hearing aids, hospice care, routine physical exam for Dependent children, Non-Contract ambulatory surgery facilities, inpatient Hospital facility services associated with single hip joint replacement or single knee joint replacement surgery, and specified surgical procedures performed in an outpatient Hospital setting.

   (3) Any amount not covered due to failure to comply with the Plan's Utilization Review Program.

Section 3.04. Hospital and Facility Benefits

a. Inpatient Services

   (1) Utilization Review Requirement. If an Eligible Individual is to be confined in a Hospital or inpatient treatment Facility, the Physician or Hospital/Facility must obtain Pre-Admission Review by the Professional Review Organization (PRO) to determine the Medical Necessity of the Hospital or Facility confinement, and if Medically Necessary, the number of authorized days determined to be Medically Necessary for the confinement. Pre-Admission Review must be obtained prior to a non-emergency Hospital or Facility confinement. In the case of an emergency confinement, the Hospital/Facility or Physician must contact the PRO within 24 hours after admission. If Utilization Review is not obtained prior to admission or retroactively, benefits will be denied under Section 8.01.b.

   (2) Benefits are payable for charges made by the Hospital for room and board, operating rooms, Drugs, medical supplies and services provided during the confinement, including any professional component of the services, including the following:

      (a) In a Non-Contract Hospital, a room with 2 or more beds, or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used, or intensive care units when Medically Necessary. In a Contract Hospital, the contract rate is covered.

      (b) In a Contract Hospital only, take home Drugs dispensed by the Hospital's pharmacy at the time of the Eligible Individual's discharge.

      (c) In a Contract Hospital only, blood transfusions including the cost of unreplaced blood, blood products and blood processing. In a Non-Contract Hospital, blood transfusions but not the cost of blood, blood products and blood processing.

      (d) In a Contract Hospital only, transportation services during a covered inpatient stay.

      (e) In a Contract Hospital only, routine newborn nursery charges.

   (3) A maximum of **$30,000** is payable for hospital inpatient facility services associated with a single hip joint replacement or a single knee joint replacement surgery.

b. Outpatient Hospital, Urgent Care Facility, provided that surgical facility services are in connection with surgery that is covered by the Plan. The maximum payable benefits listed below will apply to the following procedures when received in an outpatient hospital setting:

(1) Colonoscopy – **$1,500**

(2) Arthroscopy – **$6,000**

(3) Cataract Surgery – **$2,000**

(4) Endoscopy – **$1,000** (Effective January 1, 2017)

c. Licensed Ambulatory Surgical Facility, provided that surgical facility services are in connection with surgery that is covered by the Plan. There is a daily maximum benefit of **$300** for all services received at a Non-Contract Ambulatory Surgical Facility.

d. Skilled Nursing Facility. Benefits are provided up to a maximum of 70 days per Period of Confinement in a Skilled Nursing Facility, subject to the following:

(1) Services must be those which are regularly provided and billed by a Skilled Nursing Facility.

(2) The services must be consistent with the Illness, Injury, degree of disability and medical needs of the Eligible Individual, as determined by the PRO. Benefits are provided only for the number of days required to treat the Eligible Individual's Illness or Injury.

(3) The Eligible Individual must remain under the active medical supervision of a Physician. The Physician must be treating the Illness or Injury for which the Eligible Individual is confined in the Skilled Nursing Facility.

(4) A new Period of Confinement will begin after 90 days have elapsed since the last confinement in a Skilled Nursing Facility.

Section 3.05. Preventive Care Benefits

a. Routine Physical Exam Benefit for Dependent Children. Benefits are payable at the percentages described in Section 3.02 for routine physical examinations for Dependent children younger than age 19. For newborn children, this benefit includes Physician visits in the Hospital and Physician standby charges during a cesarean section, but not well-baby Hospital nursery charges (except for nursery charges from a Contract Hospital, see Exclusion in Section 8.01.g). For children over age 2, benefits are limited to one physical examination in any 12-month period.

b. Childhood Immunizations. Benefits are payable at the percentages described in Section 3.02 for childhood immunizations provided to a Dependent child, in accordance with the immunization schedule recommended by the American Academy of Pediatrics.

c. Routine Mammogram Benefit. Benefits are payable at the percentages described in Section 3.02 for a mammogram obtained as a diagnostic screening procedure, including digital mammography. Benefits are payable in accordance with the following schedule:

(1) For women age 35 through 39 – one baseline mammogram

(2) For women age 40 and over – one mammogram every year

d. Routine Physical Examination Benefit – For the Participant and Spouse Only. Benefits are payable at the percentages described in Section 3.02 for a routine physical examination provided by a Physician, and any x-rays and laboratory tests provided in connection with the physical examination, including pap smears or a prostate specific antigen (PSA) test for male Participants age 50 or over. Benefits are limited to one routine physical examination in any 12-month period for the Participant and Spouse only.

e. Colonoscopy / Sigmoidoscopy. The Fund will pay benefits at the percentages described in Section 3.02 for colonoscopy and sigmoidoscopy examinations received by Participants and Dependent Spouses who are considered at high risk for colon cancer, when recommended by a Physician. There is a maximum payable benefit of **$1,500** for a colonoscopy received in an outpatient hospital setting.

Section 3.06. Covered Professional Services

a. Services of a Physician, subject to the limitations and exclusions contained in the Plan.

b. Services of a registered nurse, including:

   (1) Services of a certified nurse midwife for obstetrical care during the prenatal, delivery and postpartum periods provided he or she is practicing under the direction and supervision of a Physician.

   (2) Services of a licensed nurse practitioner, provided he or she is acting within the lawful scope of his/her license, the services are in lieu of the services of a Physician and the provider is performing services under the supervision of a duly licensed Physician, if supervision is required.

c. Services of a licensed Physician Assistant, provided the services are performed under the supervision of a Physician, and subject to the following requirements:

   (1) Covered services are limited to assistant-at-surgery, physical examinations, administering injections, minor setting of casts for simple fractures, interpreting x-rays and changing dressings.

   (2) Services of the Physician Assistant must be billed under the tax identification number of the supervising Physician.

   (3) Services must be of the type that would be considered Physician services if provided by an M.D. or D.O.

   (4) For Non-Contract Providers only, Covered Expenses are limited as follows:

      (a) For assistant-at-surgery services, 85% of the amount that otherwise would be allowed if the services were performed by a Physician serving as an assistant-at-surgery, or

      (b) For other covered services, 85% of the applicable Physician's Allowed Charge for services performed.

   (5) For Contract Providers, Covered Expenses are limited to the Contract Provider negotiated rate.

d. Contraception Related Services. Professional outpatient services related to contraception are covered on the same basis as other professional services, including but not limited to services in connection with obtaining or removing a prescription contraceptive device or implant.

e. Services of a registered physical therapist provided the services are within standard medical practices and are prescribed by a Physician. Covered services do not include those services which are primarily educational, sports related, or preventive, such as physical conditioning, "back school" or exercise.

f. Services of a Podiatrist.

g. Services of a licensed speech therapist, but only for speech therapy that is provided to an Eligible Individual who had normal speech at one time and lost it due to an Illness or Injury.

h. Services of a licensed optometrist, but only when providing Medically Necessary medical treatment to the eye that is not covered by the vision plan administered by Vision Service Plan.

i. Acupuncture treatment provided by a licensed acupuncturist, subject to the following limitations:

   (1) The amount paid by the Plan will not exceed a maximum payment of **$35 per visit**.

   (2) Benefits are limited to **20 visits per calendar year**.

j. Chiropractic services provided to a Participant or Dependent Spouse by a licensed Chiropractor, subject to the following limitations:

(1) The amount paid by the Plan will not exceed a maximum payment of **$25 per visit**.

(2) Benefits are limited to **20 visits per calendar year**.

(3) No benefits are payable for chiropractic services provided to Dependent children.

k. On-line physician visits provided to a Participant or Dependent by a Contract Provider are payable at 100%, not to exceed a maximum payment of $49 per visit (Effective January 1, 2017).

Section 3.07. Additional Covered Services and Supplies

a. Licensed ambulance services for ground transportation to or from the nearest Hospital. Allowed Charges of a licensed air ambulance to or from the nearest Hospital are covered if the location and nature of the Illness or Injury made air transportation cost effective or necessary to avoid the possibility of serious complications or loss of life. Services provided by an Emergency Medical Technician (EMT) without subsequent emergency transport are paid in accordance with this Ambulance Services benefit.

b. Diagnostic radiology and laboratory services subject to the following limitations:

(1) Services must be ordered by a Physician, including laboratory tests associated with diagnosing a viral illness.

(2) The Physician must obtain pre-authorization from the Review Organization for the following outpatient diagnostic imaging services:
   (a) CT/CTA
   (b) MR/MRI
   (c) Nuclear cardiology
   (d) PET scan
   (e) Echocardiography

c. Radiation therapy and chemotherapy.

d. Artificial limbs or eyes.

e. Medical equipment and supplies. Rental charges are covered if they do not exceed the Plan Allowed Charges or purchase price of the equipment. Benefits are payable only if the equipment or supply is:

(1) Ordered by a Physician, and

(2) Of no further use when medical need ends, and

(3) Usable only by the Patient, and

(4) Not primarily for the comfort or hygiene of the Eligible Individual, and

(5) Not for environmental control, and

(6) Not for exercise, and

(7) Manufactured specifically for medical use, and

(8) Approved as effective and standard treatment of a condition as determined by the PRO, and

(9) Not for prevention purposes.

f. Contraceptive devices and implants that legally require the prescription of a Physician.

g. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Self-donated blood, limited to the Allowed Charges that would be charged if the blood were obtained from a blood bank.

h. Dental Injury. Services of a Physician (M.D.) or Dentist (D.D.S.) treating an Injury to natural teeth. Services must be received during the 6 months following the date of Injury (applied without respect to when the individual was enrolled in the Plan). Damage to teeth due to chewing or biting is not covered under this benefit.

i. Organ Transplants. The Fund will cover Covered Expenses incurred by the organ donor and the organ recipient when the organ recipient is an Eligible Individual. Covered Expenses in connection with the organ transplant include patient screening, organ procurement and transportation of the organ, surgery and Hospital charges for the recipient and donor, follow-up care in the home or a Hospital, subject to the following conditions and limitations:

(1) The transplantation is not considered an Experimental or Investigative Procedure as that term is described in Section 1.23;

(2) Anthem precertification rules are satisfied;

(3) The services provided must be approved by the Fund's PRO;

(4) The recipient of the organ is an Eligible Individual under the Plan;

(5) Benefits payable for an organ donor who is not an Eligible Individual will be reduced by any amounts paid or payable by that donor's own health coverage; and

(6) In no case will the Plan cover expenses for transportation of the donor, surgeons or family members.

j. Home Health Care. Benefits are provided in accordance with Subsections (1) and (2) below:

(1) Covered Expenses include:

(a) Services of a registered nurse.

(b) Services of a licensed therapist for physical therapy, occupational therapy and speech therapy.

(c) Services of a medical social worker.

(d) Services of a health aide who is employed by (or contracted with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as a professional coordinator.

(e) Necessary medical supplies provided by the Home Health Agency.

(2) Conditions of Service:

(a) The Eligible Individual must be confined at home under the active medical supervision of a Physician ordering home health care and treating the Illness or Injury for which that care is needed.

(b) Services must be provided and billed by the Home Health Agency.

(c) Services must be consistent with the Illness, Injury, degree of disability and medical needs of the Patient. Benefits are provided only for the number of days required to treat the Eligible Individual's Illness or Injury.

(d) Allowed Specialty Drugs are provided by the Prescription Drug Benefits and are not covered under this Home Health Care benefit. Please see Article 5 for information on Prescription Drug coverage for injectable, infusion and chemotherapy Drugs.

k. Hospice Care. If an Eligible Individual is terminally ill with a life expectancy of 6 months or less, benefits are payable for hospice care provided by an Approved Hospice Program, subject to the following conditions and limitations:

(1) Covered services must be prescribed by a Physician and are limited to the following:

(a) Nursing services by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).

(b) Medical social services by a person with a Master's degree in social work.

(c) Home Health Aide services.

(d) Medical supplies normally used by Hospital inpatients and dispensed by the hospice agency.

(e) Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.

(f) Bereavement counseling for the Patient's Dependent spouse and children who are covered under the Plan, not to exceed 8 visits within one year of the patient's death or more than $25 per visit.

(g) Respite care, not to exceed 8 days.

(2) Exclusions. No benefits will be provided for the following:

(a) Transportation.

(b) Services of volunteers.

(c) Food, clothing or housing.

(d) Services provided by household members, family, or friends.

(e) Services of financial or legal counselors.

l. Mental Health and Chemical Dependency Treatment. These benefits are paid the same as other inpatient and outpatient medical treatment under the Plan, with the following exceptions:

(1) The Deductible does not apply.

(2) Hospital emergency room care is payable at 100% of contract rates for a Contract Provider or 100% of Allowed Charges for a Non-Contract Provider.

(3) Chemical dependency inpatient and outpatient treatment at a Contract Provider is payable at 100% of contract rates.

(4) Mental Health outpatient office visits at a Contract Provider are payable at 100% of contract rates (does not include care in outpatient facilities).

m. Diabetes Instruction Programs, provided the program is recognized as an acceptable program by the American Diabetes Association.

n. Non-Contract Providers who are not registered with Centers for Medicare & Medicaid Services (CMS) who provide out-patient services, subject to the following limitations:

(1) Services must be Medically Necessary

(2) The amount allowed by the Plan will not exceed a maximum of $100 per appointment

Section 3.08. Extension of Benefits for Disability

If the Eligible Individual is Disabled and under the care of a Physician when coverage ends due to loss of eligibility, Indemnity Medical Plan benefits will continue to be provided for services treating the Illness or Injury that caused the Disability, subject to the following:

a. The extension of benefits will continue until one of the following occurs:

1) The Eligible Individual is no longer Disabled, or

2) A period of 6 consecutive months has passed since the date eligibility ended.

b. An Eligible Individual not confined as an inpatient in a Hospital or Skilled Nursing Facility must apply for Extension of Benefits by submitting written certification by the Physician that he/she is Totally Disabled. A person who is confined as an inpatient must submit this written certification after discharge from the Hospital or Skilled Nursing Facility. The Fund must receive this certification within 90 days of the date eligibility ends. At least once every 90 days while benefits are extended, the Fund must receive proof that the Eligible Individual continues to be Totally Disabled.

c. Only services treating the Disabling Illness or Injury will be covered under this Extension of Benefits.

d. Stakeholders are not eligible for this extension of benefits for Disability.

ARTICLE 4. HEARING AID BENEFITS

Section 4.01. Benefits.

Upon certification by a Physician or person with a master's or doctoral degree in audiology that a Participant or Dependent has a hearing loss, and that the loss may be lessened by the use of a hearing aid, the Fund will, subject to the provisions of this Article, pay the following benefit, up to the maximum amount shown in Section 4.02.

a. Plan A and Plan R: 100% of Allowed Charges

b. Plan B and Flat Rate Plan**:** 80% of Allowed Charges

Section 4.02. Maximum Payment for All Plans.

The Fund will pay up to a maximum payment of **$800 per year** in any 3-year period for the examination, the hearing aid and any repairs and servicing. This is the maximum benefit payable in any 3-year period for all expenses related to hearing aids.

Section 4.03. Exclusions.

No benefits will be provided for:

a. A hearing examination without a hearing aid being obtained;

b. The replacement of a hearing aid for any reason more often than once during any 3-year period;

c. Batteries or any other ancillary equipment other than that obtained upon the purchase of the hearing aid; or

d. Expenses incurred for which the individual is not required to pay.

ARTICLE 5. PRESCRIPTION DRUG BENEFITS

Section 5.01. Benefits

If prescription medicines (or insulin) are prescribed by a Physician and dispensed by a Participating Pharmacy for an Eligible Individual, the Fund will pay the Covered Expenses incurred after the Eligible Individual pays the required Copayment specified below (please note certain drugs are not covered and/or need prior authorization):

a. **Retail Pharmacy**, for each 30-day supply, the Copayment is:

(1) Formulary Generic Drug – $10

(2) Multi-Source Brand Name Drug – $10 plus the difference in cost between the generic and brand name Drugs

(3) Single Source Formulary Brand Name Drug – $40

(4) Non-Formulary Drug – $60, provided the Drug has been prior authorized or does not require prior authorization

b. **Mail Order Pharmacy**, for each 90-day supply, the Copayment is:

(1) Formulary Generic Drug – $20

(2) Multi-Source Brand Name Drug – $20 plus the difference in cost between the generic and brand name Drugs

(3) Single Source Formulary Brand Name Drug – $80

(4) Non-Formulary Drug, $100, provided the Drug has been prior authorized or does not require prior authorization

c. Any Non-Formulary Drugs on the Pharmacy Benefit Manager's Selective Prior Authorization List are not covered without prior authorization by the Pharmacy Benefit Manager.

d. Exception to Brand Name Drug Copayments for New Brand Name Drugs: For any new Brand Name Drug approved by the federal Food and Drug Administration (FDA) after June 1, 2012, including injectable and infusion Drugs, the Copayment is 50% of the cost of the Drug for a minimum of 24 months after the Drug has been approved. Subject to approval by the Board of Trustees, a new Brand Name Drug may be moved to the Copayment levels described in paragraphs (2) through (4) of Subsections a. and b. above prior to the expiration of 24 months. If the Pharmacy Benefit Manager's Pharmacy and Therapeutics committee determines that the new FDA approved Drug is a "must not add" Drug, the Copayment will remain at 50% of the cost of the Drug indefinitely.

e. Prior Approval for Proton Pump Inhibitors (PPIs) and Cholesterol drugs: Brand Name PPIs and Cholesterol drugs are subject to prior approval by the Pharmacy Benefit Manager. If prior approval is not obtained by the prescribing Physician, no benefits are payable by the Plan. If prior approval is received before a prescription is filled for a Brand Name PPI or Cholesterol drug, the Copayment level for Multi-Source Brand Name Drugs as described in paragraphs (2) of Subsections a. and b. above will apply. Participants are required to utilize the Pharmacy Benefit Manager's defined step therapy before the Plan will pay benefits for Brand Name PPIs and Cholesterol drugs.

Section 5.02. Definitions

For purposes of this Article, the following definitions will apply:

a. "Participating Pharmacy" means a pharmacy which has elected to participate in an agreement with the pharmacy benefit manager contracted by the Fund to provide services to Eligible Individuals.

b. "Non-Participating Pharmacy" means a pharmacy which has not elected to participate in an agreement with the pharmacy benefit manager contracted by the Fund to provide services to Eligible Individuals.

c. "Formulary" means the list of preferred Drugs established by the pharmacy benefit manager contracted by the Fund.

d. "Multi-Source Brand Name Drug" means a brand name Drug that has a generic equivalent.

e. "Single Source Formulary Brand Name Drug" means a brand name Drug that does not have a generic equivalent and is on the Formulary.

Section 5.03. Covered Expenses

Covered Expenses include the following Drugs or supplies provided by a Licensed Pharmacist, Physician, or Hospital:

a. Drugs prescribed by a Physician licensed by law to administer Drugs.

b. Insulin and Medically Necessary diabetic supplies. Pen products for insulin administration (except for pre-filled syringes) are covered in the following circumstances only and subject to prior authorization by the Pharmacy Benefit Manager:

   (1) Eligible Individuals who are visually impaired or have some physical impairment that prevents them from using an insulin vial and syringe.

   (2) Eligible Individuals who need an intensive insulin regimen that requires them to inject insulin at least three times per day and monitor their blood sugar at least twice a day.

   (3) Dependents under age 19.

   (4) Participants who need to inject at work.

c. Drugs, insulin and Medically Necessary diabetic supplies (1) which are supplied to the Patient in the Physician's office, and (2) for which a charge is made separately from the charge for any other item or expense.

d. Drugs, or insulin or insulin injection kits, which are furnished by a Hospital for use outside the Hospital in connection with treatment received in the Hospital, provided that with respect to Drugs, they are prescribed by a Physician licensed by law to administer Drugs.

e. Prenatal vitamins containing fluoride or folic acid.

f. Specialty Drugs, as defined by the Pharmacy Benefit Manager, is subject to the following requirements:

   (1) Specialty Drugs are available only from the Pharmacy Benefit Manager's Mail Order Pharmacy. Specialty Drugs will not be provided by a retail Participating Pharmacy and will not be covered by the Indemnity Medical Plan except for certain Drugs needed in an emergency situation; these Drugs are the low molecular weight heparin products that are used for blood clots after hip replacement surgeries.

   (2) Copayments and Supply Limit. The day supply limit for each prescription order is 30 days. The required Copayments are the Retail Pharmacy Copayments specified in Section 5.01.a.

Section 5.04. Exclusions

No benefits will be provided for:

a. Drugs taken or administered while a Patient is Hospital confined.

b. Patent or proprietary medicines which do not conform to the definition of "Drugs" set forth in Section 1.18. except for insulin, insulin injection kits, and those items listed as "Covered Expenses" in Section 5.03.

c. Appliances, devices, bandages, braces, heat lamps, splints and other supplies or equipment.

d. Vitamins (except prenatal vitamins containing fluoride or folic acid), cosmetics, dietary supplements, health and beauty aids.

e. Immunization agents, nose drops or other nasal preparations.

f. Infertility Drugs.

g. Medications for smoking cessation.

h. Appetite suppressants or any other weight loss Drug.

i. Medications prescribed for cosmetic purposes only.

j. Any Drugs not reasonably necessary for the care or treatment of Illness or Injury.

k. Charges for prescription Drugs containing in excess of 30-day supply per prescription for retail purchases, or in excess of a 90-day supply for Drugs purchased through the Fund's Mail Order Prescription Drug Program.

l. Medications with no federal Food and Drug Administration (FDA) approved indications. Off label use of prescriptions (for an indication other than described in the FDA approved drug label) will be allowed if prior approval is first obtained from the Pharmacy Benefit Manager.

m. Medications used for Experimental indications and/or dosage regimens determined to be Experimental or Investigational; any Investigational or unproven Drugs or therapies.

n. Charges for prescription Drugs purchased from Non-Participating Pharmacies unless the Eligible Individual lives more than 10 miles from a Participating Pharmacy.

o. Replacement prescription Drugs resulting from loss, theft or breakage.

p. Prescription refills dispensed after one year from original date of dispensing.

q. Injectable sexual dysfunction Drugs. Other sexual dysfunction Drugs are limited in the quantity covered.

r. The third purchase of a long-term maintenance Drug from a retail pharmacy. After the second purchase of long-term maintenance Drug at a retail pharmacy, the Drug must be purchased from the Pharmacy Benefit Manager's mail order pharmacy.

s. Provided that notice is issued by the Plan to an Eligible Individual, a single pharmacy may be designated as the sole provider to dispense one or more prescription drug class(es) to a Participant and/or Dependent. Medications dispensed by pharmacies other than named in such notice are excluded.

t. Provided that notice is issued by the Plan to an Eligible Individual, a single medical provider and/or medical facility may be designated as the sole provider of medical services for one or more conditions. Services performed by any other provider or facility other than as named in such notice are excluded.

u. Compound dermatological preparations prescribed by a Physician.

ARTICLE 6. ORTHODONTIC BENEFITS

Section 6.01. Eligibility

Orthodontic benefits descried in this Article are provided only to eligible Dependent children younger than 19 years of age.

Section 6.02. Benefits

If a Dependent child younger than 19 years of age receives orthodontic services provided by an Orthodontist, the Fund will, subject to the provisions, pay **50% of the Allowed Charge** incurred for covered orthodontic services, not to exceed a lifetime maximum per child of **$1,500**.

Section 6.03. Covered Orthodontic Services

Covered Orthodontic Services include: corrective, interceptive and preventive orthodontic treatment to realign natural teeth, to correct malocclusion, to provide pre-orthodontic guidance and to provide growth and development evaluation.

Section 6.04. Exclusions

No payment will be made for:

a. The replacement or repair of an appliance which has been lost or damaged.

b. Supplies furnished prior to the effective date of eligibility; or treatment which commenced prior to the effective date of eligibility if the Participant whose Dependent child receiving the orthodontic treatment was not eligible at the time the orthodontic treatment commenced.

c. Services furnished prior to the initial installation of an orthodontic appliance.

ARTICLE 7. SUPPLEMENTAL WEEKLY DISABILITY BENEFITS (For Plans A, B and R Only)

Flat Rate Plan Participants Are Not Entitled to This Benefit.

Section 7.01. Benefits

Supplemental Weekly Disability benefits are payable if a **Plan A, B or R Participant** becomes temporarily Disabled due to Illness or Injury while eligible under the Plan, and as a result of the Disability, is receiving either Workers' Compensation Benefits or State Disability Insurance benefits, subject to the following provisions:

a. Benefits will begin on the twenty-ninth consecutive day of Disability.

b. The maximum number of weeks payable for any one Period of Disability is 52 weeks.

c. **Benefit for Participants Receiving Temporary Workers' Compensation Benefits**. The benefit amount payable by the Plan is $63 per week.

d. **Benefit for Participants Receiving Temporary State Disability Insurance Benefits.** The benefit amount payable by the Plan is $63 per week.

   A Participant who does not reside in a state that provides State Disability Insurance Benefits is also eligible for the benefit amounts stated in this Subsection if he/she provides the Plan with written certification from a Physician approved by the Plan that he/she is Disabled as defined by the Plan.

e. The benefit amounts described in Subsections c. and d. above will be reduced by the amount of any Social Security Disability benefit or disability Pension benefit received from the Carpenters Pension Trust Fund for Northern California. In the event that permanent disability benefits are granted retroactively, the reduction to the Fund's benefit will be retroactive, and re-payment to the Fund by the Participant will be required.

f. Partial weeks of Disability are payable at one-seventh of the weekly benefit amount for each full day of Disability. No benefit will be paid for part of a day.

g. Benefits are payable only to the Participant and may not be assigned.

h. In order to be eligible for Supplemental Weekly Disability benefits, the Participant must have worked for a Contributing Employer at least 1 day within the 30-day period preceding the First Day of Disability and must have been eligible under the Plan in each of the 12 calendar months immediately preceding the First Day of Disability. Eligibility during the 12-month qualifying period must have been earned through work hours or the Hour Bank, and not as a result of a disability extension of eligibility.

Section 7.02. Periods of Disability

Successive Periods of Disability will be considered as separate Periods of Disability when they are:

a. Separated by at least 60 hours of work for which contributions are required to be made to the Fund for Plan benefits; or

b. Due to unrelated causes and separated by at least one full day of work for a Contributing Employer.

In any other cases, they will be considered as one Period of Disability.

Section 7.03. Exclusions and Limitations

Benefits provided by this Article will not be provided for the following:

a. A Dependent's disability.

b. Any Period of Disability in excess of 52 weeks.

c. Any Period of Disability which began prior to September 1, 1998.

d. A Participant who has not been eligible under the Plan in each of the 12 calendar months preceding the First Day of Disability, as defined in Subsection 1.25.

e. Any Period of Disability for which evidence of receipt of Workers' Compensation Benefits or State Disability Insurance Benefits has not been furnished to the Fund.

f. A Disability for which the Plan has not received notice of claim within 12 months of the First Day of Disability.

g. Any Period of Disability which begins while the Participant is receiving Continuation Coverage under COBRA, as described in Section 2.07.

h. A Participant who has not worked for a Contributing Employer at least one day within the 30-day period preceding the First Day of Disability, as defined in Subsection 1.25.

i. A Stakeholder of an Employer that reported hours on his/her behalf is not eligible for Supplemental Weekly Disability Benefits

ARTICLE 8. EXCLUSIONS, LIMITATIONS, AND REDUCTIONS

Section 8.01. Excluded Expenses

The Fund will not provide benefits for the following:

a. Any amounts in excess of Allowed Charges or any services not considered to be customary and reasonable.

b. Services not specifically listed in this Plan as covered services, or services which are not Medically Necessary for the treatment of an Illness or Injury (except for preventive care specifically covered by the Plan).

c. Services for which the Eligible Individual is not legally obligated to pay. Services for which no charge is made to the Eligible Individual. Services for which no charge is made to the Eligible Individual in the absence of insurance or other indemnity coverage, except services received at a non-governmental charitable research Hospital which meets the following guidelines:

   (1) It must be internationally known as being devoted mainly to medical research, and

   (2) At least 10% of its yearly budget must be spent on research not directly related to Patient care, and

   (3) At least one-third of its gross income must come from donations or grants other than gifts or payments for Patient care, and

   (4) It must accept Patients who are unable to pay, and

   (5) Two-thirds of its Patients must have conditions directly related to the Hospital's research.

d. Any work related Injury or Illness. However, the Plan will pay benefits on behalf of an Eligible Individual who has incurred an occupational Injury or Illness on the following conditions:

   (1) The Eligible Individual provides proof of denial of a Workers' Compensation claim and signs an agreement to diligently prosecute his/her claim for Workers' Compensation benefits or for any other available occupational compensation benefits; and

   (2) The Eligible Individual agrees to reimburse the Fund for any benefits paid by the Fund by consenting to a lien against any occupational compensation benefits received through adjudication, settlement or otherwise; and

   (3) The Eligible Individual cooperates with the Fund or its designated representative by taking reasonably necessary steps to secure reimbursement, through legal action or otherwise, for any benefits paid for the Eligible Individual's occupational Injury or Illness.

e. Conditions caused by or arising out of an act of war or armed invasion.

f. Services provided while an Eligible Individual is confined in a Hospital operated by the United States Government or an agency of the United States Government except that the Plan, to the extent required by law, will reimburse a Veterans Administration (VA) Hospital for care of a non-service related disability if the Plan would normally cover that care if the VA were not involved.

g. Routine nursery care of a newborn Dependent child, except as charged by a Contract Hospital.

h. Services furnished by a Naturopath or any provider not meeting the definition of a Physician.

i. Professional services received from a registered nurse or physical therapist who lives in the Eligible Individual's home or who is related to the Eligible Individual by blood or marriage.

j. Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.

k. Educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.

l. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums other than for tumors, except as specifically provided under Section 3.07.h.

m. Services of an Optometrist except as specifically provided in Section 3.06.h., vision therapy including orthoptics, routine eye exams and routine eye refractions, eyeglasses or contact lenses. Any surgery for correction of myopia or any other refractive eye surgery.

n. Cosmetic surgery or other services for beautification, except for conditions resulting from an Injury or a functional disorder or reconstructive surgery following a mastectomy.

o. Orthopedic shoes (except when joined to braces) or shoe inserts (except for custom-made orthotics), air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification.

p. Services for which benefits are payable under any other programs provided by the Fund.

q. In addition to any other limitations generally applicable to this Plan or its coordination of benefit provisions, where this Plan, as secondary is coordinating benefits with another plan which has entered into a preferred provider agreement with a medical or hospital provider, this Plan will pay no more than the difference between:

   (1) The lesser of:

      (a) The normal charges billed for the expenses by the provider, or

      (b) The contractual rate for that expense under a preferred provider agreement between the provider and the plan that this Plan is coordinating with, and

   (2) The amount that the other plan pays as primary.

r. Nutritional counseling or food supplements or substitutes, except as specifically provided in Section 3.07.m.

s. Speech therapy or occupational therapy (except rehabilitation treatment following a stroke or Injury).

t. Services to reverse voluntary surgically induced infertility.

u. Expenses for the treatment of infertility along with services to induce pregnancy and complications resulting from those services, including, but not limited to: services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen or other fees, cryostorage of egg/sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization. Expenses related to the maternity care and delivery associated with a surrogate mother's pregnancy.

v. Physical therapy services that are primarily educational, sports related or preventive, such as physical conditioning, exercise or back school.

w. Hypnotism, biofeedback, stress management, and any goal oriented behavior modification therapy, such as to quit smoking, lose weight, or control pain.

x. Services which are primarily for weight loss.

y. Claims submitted more than 12 months from date of service.

z. Any services and supplies in connection with Experimental or Investigational Procedures. For purposes of this Exclusion, the term Experimental or Investigational Procedures means a drug or device, medical treatment or procedure if:

(1) The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) The drug, device, medical treatment or procedure, or the Patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) **Reliable Evidence** shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) **Reliable Evidence** shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this Exclusion, **"Reliable Evidence"** means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

aa. Illness, Injury, disease or other condition for which a third party (or parties) is or may be liable or legally responsible by reason of an act, omission, or insurance coverage of that third party or parties unless an Eligible Individual complies with Section 8.02.

bb. Services that are habilitative in nature.

cc. Reimbursement for percentage of the amount that would have been payable in accordance with Medicare allowable payments for expenses from Non-Contract Hospital, Non-Contract Facility and other Non-Contract providers who did not complete enrollment in the Medicare program or did not submit an affidavit to Medicare expressing their decision to opt-out of the Medicare program, except as otherwise expressly provided.

dd. Provided that notice is issued by the Plan to an Eligible Individual, a single medical provider and/or medical facility may be designated as the sole provider of medical services for one or more conditions. Services performed by any other provider or facility other than as named in such notice are excluded.

Section 8.02. Third Party Liability

a. If an Eligible Individual has an Illness, Injury, disease or other condition for which a third party (or parties) is or may be liable or legally responsible by reason of an act, omission, or insurance coverage of that third party or parties (hereinafter referred to collectively as "responsible third party"), the Fund shall not be liable to pay any benefits. However, upon the execution and delivery to the Fund of all documents it requires to secure the Plan's right of reimbursement, including without limitation a Reimbursement Agreement, the Fund may pay benefits on account of Hospital, medical or other expenses in connection with, or arising out of, such Illness, Injury, disease or other condition. The Fund shall have all rights as set forth herein.

b. The Fund shall be reimbursed first, before any other claims, for 100% of benefits paid by the Fund from any recovery received by way of judgment, arbitration award, verdict, settlement or other source by the Eligible Individual or by any other person or party for the Eligible Individual, pursuant to such Illness, Injury, disease or other condition, including recovery from any under-insured or uninsured motorist coverage or other insurance, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. The Fund shall be reimbursed from said recovery without any deduction for legal fees incurred or paid by the Eligible Individual. The Eligible Individual and/or his or her attorney must promise not to waive or impair any of the rights of the Fund without written consent. In addition, the Fund shall be reimbursed for any legal fees incurred or paid by the Fund to secure reimbursement of said benefit paid by the Fund.

c. If the Fund pays any benefits because of such Illness, Injury, disease or other condition, the Fund shall also have an automatic lien and/or constructive trust on that portion of any recovery obtained by the Eligible Individual or by any other person or party for the Eligible Individual, for such Illness, Injury, disease or other condition which is due for said benefits paid by the Fund, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. Such lien may be filed with the Eligible Individual, his or her agent, insurance company, any other person or party holding said recovery for the Eligible Individual, or the court; and such lien shall be satisfied from any recovery received by the Eligible Individual, however classified, allocated, or held.

d. If reimbursement is not made as specified, the Fund, at its sole option, may take any legal and/or equitable action to recover the amount that was paid for the Eligible Individual's Illness, Injury, disease or other condition (including any legal expenses incurred or paid by the Fund) and/or may offset future benefits payments by the amount of such reimbursement (including any legal fees incurred or paid by the Fund). The Fund, at its sole option, may cease paying benefits, if there is a reasonable basis to determine that the Eligible Individual will not honor the terms of the Plan, or there is a reasonable basis to determine that this section is not enforceable.

e. By accepting benefits from the Fund, the Eligible Individual further agrees:

   (1) To prosecute any claim for damages diligently;

   (2) To promptly advise the Fund whenever a claim is made against the responsible third party with respect to any loss for which Fund benefits have been or will be paid because of an Illness, Injury, disease or other condition caused by the responsible third party;

   (3) The Fund's reimbursement rights shall be considered as a first priority claim against another person or entity, to be reimbursed before any other claims, including claims for general damages;

   (4) To cooperate and assist the Fund in obtaining reimbursement for payments made, and to refrain from any act or omission that might hinder any reimbursement;

   (5) To provide the Fund with all relevant information or documents requested;

   (6) To consent to the lien and/or constructive trust that shall exist in favor of the Fund upon all funds recovered by the Eligible Individual against the responsible third party;

   (7) To hold proceeds of any settlement, verdict, judgment or other recovery in trust for the benefit of the Fund, and that the Fund shall be entitled to recover reasonable attorney's fees incurred in collecting reimbursement of benefits due;

   (8) To execute any documents necessary to secure reimbursement;

   (9) Not to assign any rights or cause of action that the Eligible Individual may have against the responsible third party to recover medical expenses without the express written consent of the Fund;

   (10) The Fund has the right to intervene, independently of the Eligible Individual, in any legal action brought against the third party or any insurance company, including the Eligible Individual's own carrier for uninsured motorists' coverage;

   (11) The Fund's right of first reimbursement will not be affected, reduced or eliminated by the make whole doctrine, comparative fault or regulatory diligence or the common fund doctrine;

(12) It will constitute an immediate breach of the agreement and a failure to comply with the terms of the Plan, if, within 30 days following recovery from the responsible third party or insurer, the Eligible Individual does not agree to reimburse the Fund pursuant to this Section 8.02, and pay the reimbursement amount. If the Eligible Individual breaches the agreement and/or fails to comply with this Section 8.02, the amount of benefits paid by the Fund which are related to the Injury, Illness, disease or other condition will become immediately due and payable together with interest, and all costs of collection, including reasonable attorney fees and court costs.

f. If the Eligible Individual does not receive any payment from a third party to reimburse for the Illness, Injury, disease or other condition caused by the responsible third party, the Eligible Individual does not have to reimburse the Fund for any benefits properly paid to the Eligible Individual. If the Eligible Individual receives payment from the responsible third party, the Eligible Individual does not have to pay the Fund more than the amount the responsible third party paid to the Eligible Individual.

Section 8.03. Coordination of Benefits

If an Eligible Individual has the opportunity to enroll in another Group Plan which would pay benefits for hospital or medical expenses for which benefits are also due from this Fund, then the benefits provided by the Fund will be paid in accordance with the following provisions, not to exceed the dollar amount of benefits which would have been paid in the absence of other group coverage or 100% of the Covered Expenses actually incurred by the Eligible Individual.

If a Spouse has been offered the opportunity to enroll in another Group Plan sponsored by the Spouse's employer but has rejected the other Group Plan coverage, the Fund will estimate the benefits of the other Group Plan (at 80% of expenses incurred) and will coordinate its benefits with the estimated benefits that would be payable by the other Group Plan if the Spouse had not rejected coverage.

a. The benefits of the plan that covers the person as a participant, employee or subscriber are always determined before the benefits of a plan covering the person as a dependent (except when Medicare Secondary Payer provisions apply). This provision applies to any Dependent child who is covered under another plan as a participant, employee or subscriber and supersedes any other provisions of this Section 8.03 regarding Dependent children.

b. If the Eligible Individual is the Spouse of a Participant, Fund benefits otherwise payable will be coordinated with the benefits payable (or estimated to be payable if coverage has been rejected) by the other Group Plan.

c. If the Eligible Individual for whom claim is made is a Dependent child whose parents are not separated or divorced, the benefits of the Group Plan which covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year, will be determined before the benefits of the Group Plan which covers such Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs later in the calendar year. If either Group Plan does not have the provisions of this rule c. regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this rule will not apply, and the rule set forth in the Plan which does not have the provisions of this rule c. will determine the order of benefits.

d. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

e. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

f. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules d. and e. above, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other Plan which covers the child as a dependent child.

g. When rules a., b., c., d., e., or f. do not establish an order of benefit determination, Fund benefits will be provided without reduction if the Eligible Individual has been eligible continuously for benefits from this Fund for a longer period of time than he or she has been continuously eligible for benefits from the other Group Plan, provided that:

   (1) the benefits of a Group Plan covering the Eligible Individual on whose expenses claim is based as a laid off or retired employee, or Dependent of that person, will be determined after the benefits of any other Group Plan covering that person as an active employee, other than a laid off or retired employee, or Dependent of an active employee; and

   (2) if either Group Plan does not have a provision regarding laid off or retired employees, which results in each Group Plan determining its benefits after the other, then the provision (1) above will not apply.

Section 8.04. Coordination with Prepaid Plans

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event an Eligible Individual (i) has coverage under the indemnity portion of this Plan, and (ii) has coverage under a prepaid program under another Group Plan (regardless of whether the Eligible Individual must pay a portion of the premium for that plan), and (iii) uses the prepaid program for services also covered by this Plan, then this Plan will only reimburse the copayments required of the Eligible Individual under the prepaid plan, and only if such copayments are required of every person covered by that program. Except for the copayments specified above, the Plan will not pay expenses of eligible Participants or dependents covered by prepaid programs of other plans. For purposes of this Plan, the term "prepaid program" will include health maintenance organizations, individual practice associations, and any other programs that the Board in its sole discretion deems to be essentially similar to prepaid arrangements.

Section 8.05. Coordination with Medicare

If an expense is covered by both this Plan and Medicare, this Plan will pay its benefits without regard to Medicare, and Medicare may then pay the remainder of the charge subject to its applicable limitations. This Plan will pay secondary benefits after the first 30 months for beneficiaries entitled to Medicare based on end-stage renal disease.

Section 8.06. Coordination with Medicaid

Payments by this Plan for benefits with respect to an Eligible Individual will be made in compliance with any assignment of rights made by or on behalf of the Eligible Individual as required by California's plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

Where payment has been made by the State under Medicaid for medical assistance in any case where this Plan has a legal liability to make payment for that assistance, payment for the benefits will be made in accordance with any State law which provides that the State has acquired the rights with respect to an Eligible Individual to the payment for that assistance. In no event will payment be made by this Plan, under this provision, for claims submitted more than one year from the date expenses were incurred. Reimbursement to the State, like any other entity which has made payment for medical assistance where this Plan has a legal liability to make payment, will be equal to Plan benefits or the amount actually paid, whichever is less.

ARTICLE 9. GENERAL PROVISIONS

Section 9.01.

a. All benefits will be paid by the Fund to the Participant as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character and extent of the event for which the claim is payable. The Board of Trustees has the exclusive right and discretion to construe and interpret the Plan and is the sole judge of the standard of proof required in any claim and the application and interpretation of the Plan. Any dispute as to eligibility, type, amount or duration of benefits or any right or claim to payments from the Fund will be resolved by the Board or its duly authorized designee under and pursuant to the provisions of the Plan and the Trust Agreement, and its decision is final and binding upon all parties, subject only to judicial review as may be in harmony with federal labor law.

b. Proof of claim forms, as well as other forms, and method of administration and procedure will be solely determined by the Fund.

Section 9.02.

a. Except to the extent otherwise specifically provided in Subsections b. and c. of this Section or elsewhere in the Plan, each Participant, Dependent or other beneficiary is restrained from selling, transferring, anticipating or otherwise disposing of any benefit payable, or any other right or interest under the Plan, and the Fund will not be required to recognize any sale, transfer, anticipation, assignment, alienation, hypothecation or other disposition. Any benefit, right or interest is not subject in any manner to voluntary transfer or transfer by operation of law or otherwise, and is exempt from the claims of creditors or other claimants and from all orders, decrees, garnishments, executions or other legal process or proceedings not expressly authorized by federal law.

b. Any Participant may direct that benefits due him/her be paid to an institution in which the Participant or his/her Dependent is hospitalized, to any provider of medical, Drug, dental or other health services or supplies for those services or supplies, or to any other agency that may have provided or paid for, or agreed to provide or pay for, any services or supplies for which benefits are payable by the Plan.

c. In the event that through mistake or any other circumstance, a Participant, Dependent or other beneficiary has been paid or credited with more than he/she is entitled to under the Plan or under the law, or has become obligated to the Fund under an indemnity agreement or a third party liability agreement or in any other way, the Fund may set off, recoup and recover the amount of the overpayment, excess credit or obligation from benefits accrued or thereafter accruing to the Participant, Dependent or beneficiary and not yet distributed or from other assets through the Fund's collection procedures, in any installments and to the extent determined by the Board.

d. In the event that an individual employer either reports, or attempts to report, and/or contributes on behalf of any individual not eligible to have such contributions made on his/her behalf, all contributions so remitted shall be forfeited and any benefit eligibility accrued to such an individual shall immediately be terminated. Furthermore, if any benefits were paid out as a result of such hours on behalf of such individual, the Employer shall be required to reimburse the Fund for such payments.

Section 9.03. Benefits will be paid by the Fund only if notice of claim is made within 90 days from the date on which Covered Expenses were first incurred unless it is shown by the Participant not to have been reasonably possible to give notice within this time limit, but in no event will benefits be allowed if notice of claim is made beyond one year from the date on which expenses were incurred.

Section 9.04. In the event it is determined that the Participant is incompetent or incapable of handling his or her own affairs and no guardian has been appointed, or in the event the Participant has not provided the Fund with an address at which he/she can be located for payment, the Fund may during the lifetime of the Participant, pay any amount otherwise payable to the Participant to the husband or wife or relative by blood of the Participant, or to any other person or institution determined by the Fund to be equitably entitled to payment.

In the case of the death of the Participant before all amounts payable by the Plan have been paid, the Fund may pay any of those amounts to any person or institution determined by the Fund to be equitably entitled to payment. Any amount remaining will be paid to one or more of the following surviving relatives of the Participant: lawful spouse, child or children, mother, father, brothers or sisters, or to the Participant's estate, as the Board in its sole discretion may designate. Any payment in accordance with these provisions will discharge the obligation of the Fund.

Section 9.05. Claim and Appeal Procedures

a. **Definitions.**

(1) Adverse Benefit Determination. An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

(a) a payment of less than 100% of a Claim for benefits (including coinsurance or copayment amounts of less than 100% and amounts applied to the deductible);

(b) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;

(c) a failure to cover an item or service because the Fund considers it to be experimental, investigational, not medically necessary or not medically appropriate;

(d) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the claimant pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Fund).

(2) Claim. The term "Claim" means a request for a benefit made by an individual in accordance with the Fund's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Fund. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the individual pays the entire cost, the individual should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.

A request for Precertification or Prior Authorization of a benefit that does not require Precertification or Prior Authorization by the Fund as a condition for receiving maximum benefits is not considered a Claim. However, requests for Precertification or Prior Authorization of a benefit where the Fund does require Precertification or Prior Authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.

(a) Claims are Categorized as Follows:

i. Urgent Claim. The term "Urgent Claim" means a Claim for medical care or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

ii. Pre-Service Claim. The term "Pre-Service Claim" means a Claim for a benefit for which the Fund requires Precertification or Prior Authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

iii. Concurrent Claim. The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made that results in a reduction, termination or extension of the previously approved benefit.

iv. Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a claim for reimbursement for services already rendered.

v. Disability Claim. The term "Disability Claim" means any Claim that requires a finding of Total Disability as a condition of eligibility.

(3) Relevant Documents. "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Fund's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Fund rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Fund's rules were appropriately applied to a Claim.

b. **Claim Procedures.**

(1) Urgent Claims. The Fund will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Claim, and notifies the Fund of such, it will be treated as an Urgent Claim.

Urgent Claims, which may include requests for Precertification of Hospital admissions and Prior Authorization of services, must be submitted by telephone or in-person. Urgent Care Claims may not be submitted via the US Postal service.

For properly filed Urgent Claims, the Fund or its designated Review Organization will respond to the claimant and provider with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim. The determination will also be confirmed in writing.

If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Fund or its designated Review Organization will notify the claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The claimant must provide the specified information within 2 business days after receiving the request for additional information. If the information is not provided within that time, the Claim will be denied.

During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 2 business days or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information.

If a claimant improperly files an Urgent Claim, the Trust Fund Office or its designated Review Organization will notify the claimant as soon as possible but not later than 24 hours after receipt of the Claim of the proper procedures required to file an Urgent Claim. Improperly filed claims include, but are not limited to: (i) claims that are not directed to a person or organizational unit customarily responsible for handling benefit matters; or (ii) claims that do not name a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. The notification may be oral unless the claimant or authorized representative requests written notification. Unless refiled properly, it will not constitute a Claim.

(2) Pre-Service Claims. Under the terms of this Plan, Eligible Individuals are required to obtain Precertification by the Professional Review Organization (PRO) for admission to a Hospital or inpatient treatment Facility on a non-emergency basis in order to receive maximum benefits.

The Fund's designated PRO will notify the claimant of an improperly filed **Pre-Service Claim** as soon as possible, but no later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. The claimant will only receive notice of an improperly filed Pre-Service Claim if the claim is submitted to the appropriate office and includes: (i) claimant's name, (ii) claimant's specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

For properly filed Pre-Service Claims, the claimant [and the claimant's doctor] will be notified of a decision within *15 days* after receipt of the claim unless additional time is needed. The time for response may be extended for up to an additional *15 days* if necessary due to matters beyond the control of the PRO. If an extension is necessary, the claimant will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is required because the Fund needs additional information from the claimant, the Fund will issue a request for additional information that specifies the information needed. The claimant will have 45 days from the date of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until the earlier of: (i) 45 days; or (ii) the date the claimant responds to the request. The PRO then has 15 days to make a determination on the claim.

(3) Concurrent Claims. Any request by a claimant to extend an approved Urgent Claim will be acted upon by the PRO within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to continue a plan of treatment that is in progress that does not involve an Urgent Claim will be decided in enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

(4) Post-Service Claims. The claim form must be completed in full and an itemized bill(s) must be attached to the claim form in order for the request for benefits to be considered a Claim. Claimants do not have to submit an additional claim form if the bill(s) are for a continuing illness and claimant filed a signed claim form within the past calendar year period. The provider or physician may file the claim on the claimant's behalf. The claim form and/or itemized bill(s) must include the following information for the request to be considered a Claim and for the Fund to be able to decide the claim:

Claimant completes:

(a) Participant name
(b) Patient Name
(c) Patient's Date of Birth
(d) SSN of Participant or Participant ID number
(e) Date of Service
(f) Information on other insurance coverage, if any, including coverage that may be available to Participant's spouse through his or her employer
(g) If treatment is due to an accident, accident details

Provider completes:

(a) CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association) or HCPC code
(b) ICD-10 (the diagnosis code found in the *International Classification of Diseases, 10th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
(c) Billed charge (bills must be itemized with all dates of Physician visits shown)
(d) Federal taxpayer identification number (TIN) of the provider
(e) Provider's billing name, address and phone number

In the event of death, claimant must obtain a claim form and submit the written claim form and a certified copy of the death certificate to the Fund Office.

A Post-Service Claim is considered to have been filed upon receipt of the Claim by the Trust Fund Office.

Ordinarily, claimants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the Trust Fund Office. The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

If an extension is required because the Fund needs additional information from the claimant, the Fund will request additional information from provider and/or claimant via fax, telephone, Explanation of Benefits (EOB) or letter. The request shall specify the information needed. The claimant will then have 45 days from receipt of the request to supply the additional information. If the information is not provided within that time, the Claim will be denied. The deadline for making a decision on the Claim will be suspended from the date of the request for additional information until the earlier of: (i) 45 days after the request is sent; or (ii) the date the claimant responds to the request. The Fund then has 15 days to make a decision and notify the claimant of its determination.

If the Fund determines that additional information is required from the claimant, and the claimant fails to provide any requested information within 45 days, the Fund will issue a notice of Adverse Benefit Determination.

(5) Disability Claim. The initial determination of a Disability Claim will be made as soon as possible, but not later than 45 calendar days after receipt of the claim by the Fund, subject to the following:

(a) The 45-day period for making an initial determination on a request for benefits may be extended for up to 30 days, to a total of 75 days, if the Fund determines that an extension of time is necessary due to matters beyond the control of the Fund, and notifies the Claimant prior to the expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Fund expects to make a determination.

(b) If the Fund determines that a second extension of time to make a determination on the claim is necessary due to circumstances beyond the control of the Fund, and if the Fund notifies the Claimant before the end of the first 30-day extension period and gives the new date by which a determination will be made, then the period for making a benefit determination may be extended for an additional 30 days, to a total of 105 days after the initial receipt of the claim by the Fund. If an extension is necessary to make a determination on a claim for Disability benefits, the notification of the extension will specifically provide:

i. an explanation of the standards on which entitlement to a benefit is based;
ii. the unresolved issues that prevent a decision on the claim; and
iii. the additional information needed from the claimant to resolve the issues.

(c) If a claim for Disability benefits is not acted on within the time periods provided by this Section, the Claimant may proceed to the appeal procedures as if the claim was denied.

(6) Authorized Representatives. An authorized representative, such as a spouse or an adult child, may submit a Claim or appeal on behalf of a claimant if the claimant has previously designated the individual to act on his or her behalf through a form available at the Fund Office. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on the claimant's behalf. Even if the claimant has designated an authorized representative, the claimant must personally sign a claim form and file it with the Fund Office at least annually.

A health care professional with knowledge of the claimant's medical condition may act as an authorized representative in connection with an Urgent Claim without the claimant having to designate an authorized representative.

(7) Notice of Initial Benefit Determination. The claimant will be provided with written notice of the initial benefit determination. If the determination is an Adverse Benefit Determination, the notice will include:

(a) the specific reason(s) for the determination;

(b) reference to the specific Plan provision(s) on which the determination is based;

(c) a description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;

(d) a description of the appeal procedures and applicable time limits;

(e) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;

(f) if an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;

(g) if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;

(h) for Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).

c. **Appeal Procedures.**

(1) Appealing an Adverse Benefit Determination. If any Claim is denied in whole or in part, or if the claimant disagrees with the decision made on a Claim, the claimant may appeal the decision in the manner specified below. Appeals must be submitted to the Trust Fund Office within 180 days after the claimant receives the notice of Adverse Benefit Determination, must be accompanied by any pertinent material not already furnished to the Fund, and must state why the claimant believes the Claim should not have been denied.

(a) Urgent Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made either by calling the designated Review Organization or by other available similarly expeditious method.

Appeals of Urgent Claims may not be submitted via the US Postal service.

(b) Concurrent Claims. Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.

(c) Pre-Service Claims. Appeals of Adverse Benefit Determinations regarding Pre-Service Claims must be in writing via mail or facsimile. A Pre-Service Claim appeal that is received with additional information which, upon review, allows additional benefits to be approved by the Trust Fund Office or its designated Review Organization in accordance with Plan provisions will not be considered an appeal, but a new Pre-Service Claim.

(d) Post-Service and Disability Claims. The appeal of a Post-Service or Disability Claim must be submitted in writing to the Trust Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

i. the patient's name and address;
ii. the Participant's name and address, if different;
iii. a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
iv. the date of the Adverse Benefit Determination; and
v. the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

(2) The Appeal Process. The claimant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The claimant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has

appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

(3) Timeframes for Sending Notices of Appeal Determinations.

(a) Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the Trust Fund Office or its designated Review Organization.

(b) Pre-Service Claims. Notice of the appeal determination for Pre-Service claims will be sent within 30 days of receipt of the appeal by the Trust Fund Office or its designated Review Organization.

(c) Concurrent Claims. Notice of the appeal determination for a Concurrent Claim will be sent by the Trust Fund Office or its designated Review Organization prior to the termination of the benefit.

(d) Post-Service and Disability Claims. Ordinarily, decisions on appeals involving Post-Service or Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of claimant's request for review. However, if the request for review is received at the Trust Fund Office less than 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the claimant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the claimant's request for review may be necessary. The claimant will be advised in writing in advance of this extension. Once a decision on review of claimant's Claim has been reached, the claimant will be notified as soon as possible, but no later than 5 days after the date of the decision.

(e) If the decision on review is not furnished to the claimant within the time specified in this Subsection c.(3), claimant's Claim shall be deemed denied upon review. Claimant shall be free to bring an action upon his or her Claim in accordance with Subsection c.(5), below.

(4) Content of Appeal Determination Notices. The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

(a) the specific reason(s) for the determination;

(b) reference to the specific Plan provision(s) on which the determination is based;

(c) a statement that the claimant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;

(d) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal;

(e) if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and

(f) if the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

(5) When a Lawsuit May Be Started. No Employee, Dependent, beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein.

(a) A claimant may not start a lawsuit to obtain benefits until after either: (1) the claimant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination for every issue deemed relevant by the claimant and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since claimant filed a request for review and claimant has not received a final decision or notice that an extension will be necessary to reach a final decision. No legal action may be started or maintained more than two years after the date the claimant has been notified in writing that the denial of the claim has been confirmed on review.

(b) For any lawsuit filed, the determinations of the Trustees are subject to judicial review only for abuse of discretion.

(c) The provisions of this Section 9.05 shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "participant" or "beneficiary" of the Plan within the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due under the terms of the Plan, or to clarify his or her rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

Section 9.06. The Fund, at its own expense, has the right and opportunity to examine the person of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

Section 9.07. The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

Section 9.08. The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of the Plan and the provisions of the Trust Agreement, the provisions of the Trust Agreement will prevail.

Section 9.09. Privacy and Right to Receive and Release Necessary Information

a. For the purpose of determining the applicability of and implementation of the terms of Sections 8.03 through 8.06 dealing with Coordination of Benefits of this Plan or any provision of similar purpose of any other plan, the Plan may, to the extent consistent with Federal and state privacy laws (to the extent applicable) and the Plan's Privacy Procedures, release to or obtain from an insurance company or other organization or person any information, with respect to any person, that the Plan deems to be necessary for such purposes.

b. The Trustees and appropriate professionals retained by the Plan, may, to the extent necessary and in accordance with Federal and state privacy laws (to the extent applicable) and the Plan's Privacy Procedures, have access to such Protected Health Information regarding Participants and Dependents as is reasonably necessary to make eligibility, payment, claims and appeals decisions, or as otherwise necessary to the administration of the Plan.

c. The Trustees shall develop Privacy Procedures in accordance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable laws, and shall furnish to each Participant and Dependent a Notice of Privacy Practices. Such policies and practices shall be consistent with applicable Federal and state laws.

d. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The following are permitted and required uses and disclosures of Protected Health Information, as that term is defined in HIPAA, that may be made by the Plan sponsor, the Board of Trustees.

(1) The Board of Trustees may make the following permitted and required disclosures of Protected Health Information. All disclosures shall be of the Minimum Necessary information, as that term is defined under HIPAA, except in the case of Subsections (o) through (s) below.

<u>Permitted Disclosure Purposes:</u>

(a) As necessary for claims payment, Plan operations and treatment, including for the purpose of de-identifying information for further permitted disclosure.

(b) Determining eligibility and amount of benefits.

(c) Determining medical necessity, utilization reviews, and precertifications.

(d) Processing claims, auditing claims, investigating claims, responding to Participant inquiries regarding claims, and insuring proper claims payment.

(e) Subrogation and other third-party recovery processing.

(f) Determining proper employer contributions.

(g) Processing and determining stop loss coverage.

(h) Claims and appeals processing.

(i) Quality assessment, case management, provider rating, underwriting (the Plan does not use or disclose PHI that is genetic information for underwriting purposes), enrollment and premium rating, patient safety activities, and other related activities.

(j) Legal and auditing services, including Plan compliance.

(k) Plan design analysis, including cost analysis and Plan change evaluations.

(l) Implementation of HIPAA and other applicable laws.

(m) Tax and other regulatory filings.

(n) Disclosures to the covered individual.

(o) Disclosures that are subject to a specific written authorization from the covered individual.

(p) Uses that are incident to a use or disclosure otherwise permitted or required by law.

Required Disclosures:

(a) To the covered individual, when requested, to the extent required by law.

(b) When requested, to the Secretary of Health and Human Services;

(c) Any other instance in which HIPAA explicitly permits the use or disclosure without authorization.

(2) Further, the Board of Trustees will:

(a) Not use or further disclose the information other than as permitted or required by the Rules and Regulations and Privacy Procedures, or as required by law.

(b) Ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Trustees with respect to such information.

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make available Protected Health Information in accordance with HIPAA.

(f) Make available Protected Health Information for amendment by Participants and Dependents and incorporate any amendments to Protected Health Information in accordance with HIPAA.

(g) Make available the information required to provide an accounting of non-routine disclosures in accordance with HIPAA.

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received form the Plan available to the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated for purposes of determining compliance by the Plan with the regulations requiring the Plan's Privacy Procedures and this Section.

(i) To the extent feasible, return or destroy all Protected Health Information received from the Plan that the Trustee(s) still maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) Ensure the adequate separating required by the following Section 9.09.d.(3).

(3) The Board of Trustees and the Plan shall be treated as separate and distinct entities for purposes of these privacy rules. To that end, only the following persons or entities shall be authorized by the Trustees to have access to Protected Health Information and such access shall be solely for the specific Plan-related functions performed by such persons or entities.

(a) The Plan's administrator and its employees, including claims adjusters, benefits and eligibility staff, and accounting personnel.

(b) Utilization review and case management providers and their employees.

(c) Claims repricing provider and its employees, including health services purchasing coalitions.

(d) The Plan's business associates, including attorneys, actuaries, consultants and accountants.

(e) PPO organizations and stop loss carriers.

(f) Medical review consultants and firms.

(g) Prescription drug benefit providers.

(h) Dental and vision plan providers.

(i) Mental health and substance abuse treatment providers.

(j) Other service providers that require Protected Health Information to perform services for the Plan.

(k) Off-site storage providers who maintain the Plan's archival records.

(4) Noncompliance. In the event any person or entity to which the Plan has provided Protected Health Information in accordance with this Subsection d. uses or discloses such information in a manner inconsistent with the Plan, its Privacy Procedures, or applicable law, the Trustees shall have the right to:

(a) Notify such person or entity in writing of such violation and demand immediate correction and remedial measures be taken to correct such use or disclosure.

(b) Assess against such person or entity the actual costs of the corrective or remedial action described in Subsection (a).

(c) Send a letter of reprimand to any such person or entity that repeatedly commits such violations.

(d) Take such additional appropriate action including, to the extent feasible, terminating the Plan's relationship with such person or entity, or reporting such violations to the Secretary of Health and Human Services.

e. Security Regulations. The Board will implement measures to comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan, except for ePHI that: (1) the Plan receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508).

The Board will, in accordance with the Security Regulations:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Plan creates, receives, maintains or transmits.

(2) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan will use ePHI only for Plan administration activities and not for employment related actions or for any purpose unrelated to Plan administration. Any Trustee, Plan professional, employee or other fiduciary of the Plan who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision will be subject to the Plan's disciplinary procedures as described in Section 9.09.d. (4).

(3) Ensure that any agent or subcontractor to whom the Plan provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

(4) The Plan Administrator will report to the Board any Security Incident of which he becomes aware.

ARTICLE 10. AMENDMENT AND TERMINATION

Section 10.01. The Board has determined that each of the conditions, limitations and other terms of this Plan is essential to carry out the obligation of the Fund to provide comprehensive Hospital, medical and other benefits to all Participants. In furtherance of that obligation, the Board expressly reserves the right, in its sole discretion at any time, upon a non-discriminatory basis:

a. To terminate or amend either the amount or condition with respect to any benefit even though the termination or amendment affects claims which have already accrued;

b. To alter or postpone the method or payment of any benefit; and

c. To amend or rescind any other provisions of the Plan.

ARTICLE 11. DISCLAIMER

Section 11.01. Only the Member Assistance Program benefits and Plan A life insurance and accidental death and dismemberment benefits are insured by a contract of insurance. None of the other benefits provided in the Plan are insured by any contract of insurance and there is no liability on the Board or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for that purpose.

AMENDMENT NO. 2
To the
Carpenters Health and Welfare Trust Fund for California
Rules and Regulations
Combined For Plan A, B, R and Flat Rate Plans
Amended and Restated Effective November 1, 2016

A. Effective January 1, 2017, the following changes are made to Article 7, Supplemental Weekly Disability Benefits:

1. The following new Subsection 7.03.j. is added as follows:

j. A Participant who is in receipt of a monthly Pension benefit from the Carpenters Pension Trust Fund for Northern California.

B. Effective January 1, 2017, the following changes are made to Article 8, Indemnity Medical Plan Benefits:

1. Subsection 8.01.x. is restated as follows:

x. Non-surgical services for weight loss.

C. Effective June 1, 2017, the following changes are made to Article 3, Indemnity Medical Plan Benefits:

1. The following new Subsection 3.01.g. is added as follows:

g. The deductible does not apply to screening services provided by Health Dynamics.

2. The following new Subsection 3.01.h. is added as follows:

h. The deductible does not apply to health coaching services provided by Trestle Tree.

3. The following new Subsection 3.02.c.(3)(e) is added as follows:

e. The benefit payable for screening services by Health Dynamics is 100% of the negotiated fees as set forth in Subsection 3.05.f.

4. The following new Subsection 3.02.c.(4)(e) is added as follows:

e. The benefit payable for screening services provided by Health Dynamics is 100% of the negotiated fees as set forth in Subsection 3.05.f.

5. The following new Subsection 3.02.c.(3)(f) is added as follows:

f. The benefit payable for health coaching services provided by Trestle Tree is 100% of the amount charged by Trestle Tree as set forth in Subsection 3.07.o.

6. The following new Subsection 3.02.c.(4)(f) is added as follows:

f. The benefit payable for health coaching services by Trestle Tree is 100% of the amount charged by Trestle Tree as set forth in Subsection 3.07.o.

7. The following new Subsection 3.05.f. is added as follows:

f. Health Dynamics. Benefits are payable at the percentages described in Section 3.02, for screening services conducted by Health Dynamics.

8. Subsection 3.07.k. is deleted.

9. Subsection 3.07.l. through Section 3.07.n. are renumbered Section 3.07.k. through 3.07.m.

10. The following new Subsection 3.07.n. is added as follows:

n. Health Coaching. Benefits are payable at the percentages described in Section 3.02 for coaching through the Trestle Tree program for all services related to wellness and disease management provided by Trestle Tree.

D. Effective August 1, 2017, Section 3.05.a. is restated as follows:

a. Routine Physical Exam Benefit for Dependent Children. Benefits are payable at the percentages described in Section 3.02 for routine physical examinations for Dependent children. For newborn children, this benefit includes Physician visits in the Hospital and Physician standby charges during a cesarean section, but not well-baby Hospital nursery charges (except for nursery charges from a Contract Hospital, see Exclusion in Section 8.01.g.).

F. Effective September 1, 2017, the following changes are made to Article 1, Definitions:

1. Section 1.15 is amended and restated as follows:

Section 1.15. The term "Dependent" means:

a. The Participant's lawful spouse or qualified Domestic Partner.

b. A child who is:

(1) the Participant's natural child, stepchild or legally adopted child, or a child of the Participant required to be covered under a Qualified Medical Child Support Order, who is younger than 26 years of age, whether married or unmarried. Adopted children are eligible under the Plan when they are placed for adoption.

(2) an unmarried child for whom the Participant has been appointed legal guardian, provided the child is younger than 19 years of age and is considered the Participant's dependent for federal income tax purposes;

(3) an unmarried child of the Participant's qualified Domestic Partner, provided the child is younger than 19 years of age and is primarily dependent on the Participant for financial support;

(4) an unmarried child eligible under paragraph (2) or (3) above other than age who is 19 but less than 23 years of age and a full time student at an accredited educational institution, provided the child otherwise meets the requirements of paragraph (2) or (3) above. Temporary absence from the Participant's place of abode due to education is not treated as absence for purposes of satisfying the residence requirement of paragraphs (2) and (3) of this Subsection; or

(5) an unmarried child of the Participant (or child of the Participant's spouse or qualified Domestic Partner) of any age who is prevented from earning a living and primarily dependent on the Participant for financial support due to a medical condition and submits written documentation by their Physician to support his/her condition, and provided the child had such condition while an eligible Dependent under this Plan before reaching the Limiting Age described in paragraphs (1), (2), (3), or (4) above.

c. In accordance with ERISA Section 609(a), this Plan will provide coverage for a child of a Participant if required by a Qualified Medical Child Support Order, including a National Medical Support Order. A Qualified Medical Child Support Order or National Medical Support Order will supersede any requirements in the Plan's definition of Dependent stated above.

2. Section 1.16 is amended and restated as follows:

Section 1.16. The terms "Disabled" and "Disability" mean:

a. For purposes of the Disability Extension described in Section 2.05 and the Supplemental Weekly Disability Benefits in Article 7., that the Participant is in receipt of Temporary Workers' Compensation Benefits, or State Disability Insurance Benefits (SDI).

b. For purposes of the Extension of Benefits for Disability in Section 3.08, that the Participant is in receipt of Temporary Workers' Compensation Benefits, or State Disability Insurance Benefits (SDI).

c. In the case of a Dependent child's eligibility, a disabled child means one who is prevented from earning a living and primarily dependent on the Participant for financial support due to a medical condition and submits written documentation by their Physician to support his/her condition, and provided the child had such condition while an eligible Dependent under this Plan before reaching the Limiting Age described in Section 1.15 paragraphs (1), (2), (3), or (4). The term "Temporary Disability" or "Temporarily Disabled" means that the Participant is in receipt of Temporary Workers' Compensation Benefits or State Disability Insurance Benefits (SDI). Periods of Disability will be considered separate Periods of Disability when they are separated by at least 60 hours of work for which contributions are required to be made to the Fund for Plan benefits.

3. Section 1.25 is amended and restated as follows:

Section 1.25. The term "First Day of Disability" means the date the Participant began receiving Workers' Compensation Benefits, or on the claim effective date established by State Disability Insurance.

G. Effective September 1, 2017, the following changes are made to Article 2, Eligibility for Benefits

1. A new Subsection 2.05.a.(4) is added as follows:

(4) Notwithstanding Sections (1) through (3) above, all hours worked as a Stakeholder will be excluded.

H. Effective September 1, 2017, the following changes are made to Article 3, Indemnity Medical Plan Benefits:

1. The first paragraph of Section 3.08 is restated as follows:

If the Eligible Individual is Disabled (as defined in Section 1.16) , Indemnity Medical Plan benefits will continue to be provided for services treating the Illness or Injury that caused the Disability, subject to the following:

I. Effective September 1, 2017, the following changes are made to Article 7, Supplemental Weekly Disability Benefits (For Plan A, B and R only):

1. Section 7.01 is restated as follows:

Supplemental Weekly Disability benefits are payable if a **Plan A, B or R Participant** is receiving either Workers' Compensation Benefits or State Disability Insurance benefits, subject to the following provisions:

a. Benefits will begin on the twenty-ninth consecutive day of Disability.

b. The maximum number of weeks payable for any one Period of Disability is 52 weeks.

c. **Benefit for Participants Receiving Temporary Workers' Compensation Benefits.** The benefit amount payable by the Plan is $63 per week.

d. **Benefit for Participants Receiving Temporary State Disability Insurance Benefits.** The benefit amount payable by the Plan is $63 per week.

e. A Participant who does not reside in a state that provides State Disability Insurance Benefits is also eligible for the benefit amounts stated in Subsection d. if he/she provides the Plan with written certification from a Physician approved by the Plan that he/she is Disabled as defined by the Plan.

f. The benefit amounts described in Subsections c. and d. above will be reduced by the amount of any permanent Social Security Disability benefit, permanent Workers' Compensation benefit or disability Pension benefit received from the Carpenters Pension Trust Fund for Northern California. In the event that permanent disability benefits are granted retroactively by the Social Security Administration or Workers' Compensation, the reduction to the Fund's benefit will be retroactive, and re-payment to the Fund by the Participant will be required.

g. Partial weeks of Disability are payable at one-seventh of the weekly benefit amount for each full day of Disability. No benefit will be paid for part of a day.

h. Benefits are payable only to the Participant and may not be assigned.

i. In order to be eligible for Supplemental Weekly Disability benefits: the Participant must have worked for a Contributing Employer at least 1 day within the 30-day period preceding the First Day of Disability and must have been eligible under the Plan in each of the 12 calendar months immediately preceding the First Day of Disability. Eligibility during the 12-month qualifying period must have been earned through work hours or the Hour Bank, excluding any hours worked as a Stakeholder and not as a result of a disability extension of eligibility.

2. Section 7.02 is amended and restated as follows:

Successive Periods of Disability will be considered as separate Periods of Disability when they are separated by a new First Day of Disability. In any other cases, they will be considered as one Period of Disability.

J. Effective September 1, 2017, the following changes are made to Article 9 General Provisions:

1. Subsection 9.05.a.(2)(a)v. is restated as follows:

v. Disability Claim. The term "Disability Claim" means any Claim under Section 2.05.c. or Section 7.01.e when the written certification from a Physician states the applicant is Disabled as defined by the Plan but the Plan nevertheless issues a disability benefit denial.

2. A new Subsection 9.05.b.(5)d. is added as follows:

(d) Disability Claim.

i. The term "Disability Claim" means any Claim under Section 2.05.c. or Section 7.01.e when the written certification from a Physician states the applicant is Disabled as defined by the Plan but the Plan nevertheless issues a disability benefit denial.

ii. Effective for Disability Claims filed on or after April 1, 2018, to ensure that all claims and appeals for disability benefits under Section 2.05.c. or Section 7.01.e.

when the written certification from a Physician states the applicant is Disabled as defined by the Plan but the Plan nevertheless issues a disability benefit denial, are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making decision, decisions covered by the authority of this Plan regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) making determinations with respect to under Section 2.05.c. or Section 7.01.e of the Plan will not be made based upon the likelihood that the individual will support the denial of benefits.

3. Subsection 9.05.a.(3) is restated as follows:

(3) **Relevant Documents.** "Relevant Documents" could include specific Fund rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Fund's rules were appropriately applied to a Claim, including documents pertaining to a Claim if:

(a) They were relied upon in making the benefit determination,

(b) They were submitted, considered or generated in the course of making the benefit determination,

(c) They demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Fund's policy or guidance with respect to the denied treatment option or benefit.

(d) For Disability Claims, they constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimants diagnosis, without regard to such advice or statement that was relied upon in making the benefit determination.

K. Effective for disability claims filed on or after April 1, 2018, the following changes are made to Article 9 General Provisions:

1. A new Subsection 9.05.b.(8) is added as follows:

(8) In addition to the required information described in Subsection 9.05.b.(7), the written notification of the benefit denial of a disability benefit under Section 2.05.c and 7.01.e. of the Plan when the written certification from a Physician states the applicant is Disabled as defined by the Plan but the Plan nevertheless issues a disability benefit denial will set forth, in a manner calculated to be understood by the applicant, the following:

i. a discussion of the decision, including the basis for disagreeing with or not following:

a) A treating physician or vocation professional who evaluated the claimant;

b) The views of medical or vocational experts obtained by the plan, and

c) Any disability determination by the Social Security Administration.

ii. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

iii. Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist;
iv. A statement when the claim is denied that the claimant is entitled to receive relevant documents upon request;
v. A statement that no legal actions may be commenced or maintained against the Health and Welfare Trust Fund for California and/or the Board of Trustees more than two (2) years after a claim has been denied and
vi. Notifications shall be provided in a culturally and linguistically appropriate manner in accordance with the requirements described in DOL Reg. §2560.503-1(o).

2. Subsection 9.05.c.(2) is amended and restated as follows:

(2) The Appeal Process.

(a) The claimant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The claimant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

(b) Before the Board of Trustees can issue an adverse benefit determination on review of a disability benefit claim under Section 2.05.c. or Section 7.01.e. of the Plan when the written certification from a Physician states the claimant is Disabled as defined by the Plan but the Plan nevertheless issues a disability benefit denial, based on a new or additional rationale, the Board of Trustees shall provide the claimant automatically and free of charge, with any new or additional evidence and/or additional rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence/rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of appeal is required to be provided) to give claimant a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the disability claim filing or disability claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

3. Subsection 9.05.c.(3)(e) is restated and Subsection 9.05.c.(3)(f) is added as follows:

(e) If the decision on review is not furnished to the claimant within the time specified in this Subsection c.(3), claimant's Claim shall be deemed denied upon review. Claimant shall be free to bring an action upon his or her Claim in accordance with Subsection c.(5), below.

(f) For disability benefit claims under Section 2.05.c. or Section 7.01.e. of the Plan when the written certification from a Physician states the claimant is Disabled as defined by the Plan but the Plan nevertheless issues a disability benefit denial, administrative procedures will not be deemed to be exhausted if the Plan's violation was *de minimis* and did not cause, and is not likely to cause, prejudice or harm to the claimant (if the Plan demonstrates that the violation was for good cause or beyond the control of the Plan and the violation occurred in context of good faith exchange of information between the Plan and the claimant). If the Plan does not provide a written explanation within 10 days of a written request, the claim will be deemed denied.

4. Subsections 9.05.c.(4)(g) and 9.05.c.(4)(h) are added as follows:

(g) For disability benefit claims under Section 2.05.c. or Section 7.01.e. of the Plan when the written certification from a Physician states the claimant is Disabled as defined by the Plan but the Plan nevertheless issues a disability benefit denial, the notice of denial will also include:

i. a discussion of the decision, including the basis for disagreeing with or not following:

a. The views presented by the claimant to the Plan of healthcare professionals treating the claimant and vocational professionals who evaluated the claimant;

b. The view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

c. Any disability determination by the Social Security Administration.

ii. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

iii. Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist;

iv. A statement when the claim is denied that the claimant is entitled to receive relevant documents upon request; and to respond to new information by presenting written evidence and testimony.

(h) Notifications shall be provided in a culturally and linguistically appropriate manner in accordance with the requirements described in DOL Reg. §2560.503-1(o).

5. Subsection 9.05.c.(5) is added as follows:

(5) Exhaustion of Administrative Remedies

Generally, if the Plan fails to establish or follow claims procedures consistent with the requirements of the Section 9.05, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under ERISA 502(a).

In addition, if the Plan fails to strictly adhere to all the requirements of the Section with respect to disability benefit claims with regard to Section **2.05.c. or Section 7.01.e.**, the claimant will be deemed to have exhausted to administrative remedies available under the Plan (unless the violations are "de minimis" in accordance with DOL Reg. 2560.503.-1(1)(2)(ii)), the claim or appeal will be deemed denied on review without the exercise of discretion by an appropriate fiduciary, and the claimant shall be entitled to pursue any available remedies under ERISA 502(a).

6. **Subsection 9.05.c.(5) is renumbered as 9.05.c.(6).**

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

June 27, 2017

To: **All Active Plan Participants, Non-Medicare Retirees and their Dependents, including COBRA Beneficiaries**

From: **BOARD OF TRUSTEES**
Carpenters Health and Welfare Trust Fund for California

Re: **BENEFIT CHANGES – INDEMNITY MEDICAL PLAN**
- **Health Dynamics Physical Exam and Health Coaching**
- **Trestle Tree Review of Claims and Health Coaching**

This Participant Notice will advise you of changes that have been made to your medical benefits. This information is very important to you and your dependents. Please take the time to read it carefully.

Effective July 1, 2017, the Board of Trustees of the Carpenters Health and Welfare Trust Fund modified Plan Rules and Regulations to include a new preventive care program to supplement the existing benefits of your plan. The Fund contracted with Health Dynamics and Trestle Tree to identify possible health problems and help you and your spouse maintain or improve your health.

This new benefit will permit you to elect one of the following options:

- Have a **comprehensive physical exam with Health Dynamics** at no charge to you and/or your spouse and participate in a health coaching session; or

- **Enroll with Trestle Tree: your medical claims/data** will be reviewed by Trestle Tree and their health coaches will reach out to you and/or your spouse.

HEALTH DYNAMICS PHYSICAL EXAM

If you and/or your spouse choose to have the FREE physical exam, please call Health Dynamics at 866-443-0164 to make an appointment. Your exam may include the following services depending on such things as your age or gender:

- Comprehensive health history questionnaire;
- Physician directed physical exam;
- Blood chemistry and/or urine analysis;
- Blood pressure measurement;
- Electrocardiogram;
- Cardiovascular fitness exam - bike or treadmill;
- Pap smear & screening mammogram;
- Prostate cancer screening;
- Colorectal cancer screening;
- Strength and flexibility assessment;
- Measurement of height, weight & body fat percentage;
- Pulmonary function (lung function) testing;
- Analysis of diet;
- Stress inventory; and
- A follow-up one-hour wellness coaching/consultation session scheduled a few weeks after your initial appointment.

TRESTLE TREE HEALTH COACHING

Under this coaching program, Trestle Tree will review the medical claims data for you and/or your spouse and a health coach will reach out to you and/or your spouse directly to discuss ways to improve your health. For example, you may discuss the following issues with your health coach:

- Weight Management;
- Tobacco Cessation;
- Exercise;
- Nutrition;
- Stress Management; or
- Management of an existing health condition.

Health Dynamics, Trestle Tree and the Fund will maintain the privacy of your health information and your claims data. Aggregate health information may be shared to help the Fund design a program based on identified health risks in the workplace. However, your individual information will not be shared with your employer.

* * * *

Grandfathered Health Plan: The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California believes the Fund's Indemnity medical plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plan, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plans to change from grandfathered health plan status can be directed to the plan administrator or the Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Please keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.carpenterfunds.com.

The Board of Trustees maintains the right to change or discontinue the types and amounts of benefits under this Plan. This notice is intended as a summary only, and actual Plan documents will be used to interpret the Plan. Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. No individual Trustee, Employer or Union Representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA
265 Hegenberger Road, Suite 100
P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

July 20, 2018

To: All Active Participants and their Beneficiaries – Plan A and Plan R

From: BOARD OF TRUSTEES
Carpenters Health and Welfare Trust Fund for California

Re: SUMMARY OF BENEFITS AND COVERAGE (SBC) required by the Affordable Care Act (ACA)

As required by law, group health plans like ours are providing plan participants with a Summary of Benefits and Coverage (SBC) as a way to help understand and compare medical benefits. The SBC provides a brief overview of the medical plan benefits provided by the Carpenters Health and Welfare Trust Fund for California. Please share this SBC with your family members who are also covered by the Plan.

Each SBC contains concise medical plan information in plain language about benefits and coverage. This includes what is covered, what you need to pay for various benefits, what is not covered, and where to go for more information or to get answers to questions. Government regulations are very specific about the information that can and cannot be included in each SBC. The Plan is not allowed to customize much of the SBC. An SBC includes:

- A health plan comparison tool called "Coverage Examples." These examples illustrate how the medical plan covers care for two common health scenarios: having a baby and diabetes care. These examples show the projected total costs associated with each of these two situations, how much of these costs the Plan covers and how much you, the participant, need to pay. In these examples, it's important to note that the costs are national averages and do not reflect what the actual services might cost in your area. Plus, the cost for your treatment might also be very different depending on your doctor's approach, whether your doctor is an In-Network PPO Provider or a Non-PPO Provider, your age and any other health issues you may also have. These examples are there to help you compare how different health plans might cover the same condition—not for predicting your own actual costs.
- A link to a "Glossary" of common terms used in describing health benefits, including words such as *"deductible," "co-payment,"* and *"co-insurance."* The glossary is standard and cannot be customized by a Plan.
- Websites and toll-free phone numbers you can contact if you have questions or need assistance with benefits.

Please keep this notice with your benefit booklet. If you have any questions, please call Benefit Services at the Trust Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.carpenterfunds.com or call 1-888-547-2054. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.carpenterfunds.com or call 1-888-547-2054 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Contract Provider: $128/individual per calendar year; $256/family per calendar year. Non-Contract Provider: $257/person per calendar year; $514/family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Mental health, chemical dependency (including detox), member assistance program visits, Contract Provider On-line physician visits up to $49 per visit, and outpatient prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	There is no out-of-pocket limit on all types of cost sharing, but there is a $1,289/person ($2,578/family) on the amount of coinsurance that you must pay for covered services in a year.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, hearing examination and hearing aid expenses, penalties for failure to obtain precertification, deductibles, expenses from Non-Contract providers, outpatient retail/mail order prescription drug expenses, amounts over the reference-based pricing allowances and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-888-547-2054 for a list of Contract providers in California. See www.bcbs.com or call 1-800-810-2583 for a list of Contract providers outside the state of California.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab

Important Questions	Answers	Why This Matters:
		work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Specialist visit	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Preventive care/screening/ Immunization	10% coinsurance	30% coinsurance	• For adults and children between ages 2 and 18, benefits are limited to one routine physical exam in any 12-month period. • You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. • Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Professional/physician charges may be billed separately (Services from Non-Contract providers not registered with CMS are limited to $100/appointment). Precertification is required for CT/CTA, MRI, Nuclear Cardiology, Pet Scans and Echocardiography.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call 1-800-939-7093.	Generic drugs	Retail: $15 copay/fill. Mail order: $26 copay/fill	You pay 100% (unless there are no network pharmacies within 10 miles). Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	• Retail Pharmacy – 30-day supply • Mail Order Pharmacy – 90-day supply • Deductible does not apply to outpatient prescription drugs. • Cost sharing for outpatient prescription drugs **does not count** toward the out-of-pocket limit. • If the cost of the drug is less than the copay, you pay just the drug cost. • Brand name Proton Pump Inhibitors (PPI) and Cholesterol drugs not covered. • For any new Brand Name Drug approved by the federal FDA, including injectable and infusion drugs, the copay is 50% of the cost of the drug for a minimum of 24 months after the drug has been approved. If the PBM determines that the new FDA-approved drug is a "must not add" drug, the copay will remain at 50% of the cost of the drug. • Mail Order is mandatory if more than 2 prescriptions are filled for maintenance medications.
	Preferred brand drugs (Formulary brand drugs)	Retail: $15 copay/fill + cost difference between generic and brand for multi-source brand. $53 copay/fill for single-source formulary brand. Mail order: $26 copay/fill + cost difference between generic and brand for multi-source brand. $106 copay/fill for single-source formulary brand.		
	Non-preferred brand drugs (Non-formulary brand drugs)	Retail: $80 copay/fill; Mail Order: $133 copay/fill		
	Specialty drugs	Subject to Retail Copays (30-day supply).	Not covered	Specialty drugs are available only from the PBM's Mail Order Pharmacy (except certain emergency drugs may be provided by a retail Participating Pharmacy).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance plus any amounts over $300	For the hospital facility charge, a maximum of $6,000 is payable for an arthroscopy, $2,000 for cataract surgery, $1,500 for colonoscopy, and $1,000 for endoscopy. Precertification is recommended for outpatient surgery.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	***Medical:*** 10% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 30% coinsurance (10% coinsurance if no choice in hospital due to emergency). ***Mental Health or Substance Abuse:*** No charge	Professional/physician charges may be billed separately. (Services from Non-Contract providers not registered with CMS are limited to $100/appointment).
	Emergency medical transportation	10% coinsurance	10% coinsurance.	Limited to emergency care or medically necessary inter-facility transfer to the nearest hospital, only. Services provided by an Emergency Medical Technician (EMT) without subsequent emergency transport are covered. *See Article 1 of the Plan Document for more information on emergency care.
	Urgent care	***Medical:*** 10% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 30% coinsurance (10% coinsurance if no choice in hospital due to emergency). ***Mental Health or Substance Abuse:*** No charge	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	• Precertification is required. • A maximum of $30,000 is payable for the hospital facility charges associated with a single hip joint or knee joint replacement surgery. • In a Non-Contract Hospital, the plan covers a room with 2 or more beds (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used). • Services from Non-Contract providers not registered with CMS are not covered.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	***Mental Health:*** Office visit: No charge, deductible does not apply. Other outpatient services: 10% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply	30% coinsurance, deductible does not apply.	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Inpatient services	***Mental Health:*** 10% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply.	30% coinsurance, deductible does not apply.	• Precertification is required. • In a Non-Contract Hospital, the plan covers a room with 2 or more beds (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used) • Services from Non-Contract providers not registered with CMS are not covered.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	• Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). • Services from Non-Contract providers not registered with CMS are limited to $100/appointment
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Precertification is required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. Services from Non-Contract providers not registered with CMS are not covered.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Rehabilitation services	10% coinsurance	30% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $100/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered.
	Habilitation services	Not covered	Not covered	You pay 100% for this service, even in-network.
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification is recommended. Limited to 70 days per confinement. Services from Non-Contract providers not

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
				registered with CMS are not covered.
	Durable medical equipment	10% coinsurance	30% coinsurance	Rental covered up to reasonable purchase price.
	Hospice services	10% coinsurance	30% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $100/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered. Covered if terminally ill. Respite care is limited to 8 days.
If your child needs dental or eye care	Children's eye exam	$10 copayment	$10 copayment	Vision benefits are available through a separate vision plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	$25 copayment, plus all amounts over $150 for frames	$25 copayment, plus all amounts over $35 for single vision lenses and amount over $45 for frames	
	Children's dental check-up	No charge, a deductible does not apply to these services.		Limited to $2,500/person for Contract and $2,000/person for Non-Contract per calendar year. Dental benefits are available through a separate dental plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (up to $35/visit and 20 visits per calendar year)
- Bariatric surgery (with precertification)
- Chiropractic care (Employee and spouse only. Up to $25/visit up to 20 visits per calendar year)
- Dental care (Adult) (up to $2,500 for Contract and $2,000 for Non-Contract per calendar year)
- Hearing aids (limited to $800/ear in any 3-year period)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (under separate vision plan)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Trust Fund Office at 1-888-547-2054. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-547-2054.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-547-2054.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-547-2054.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$128**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$128
Copayments	$90
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$1,468

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$128**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$128
Copayments	$580
Coinsurance	$290
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,058

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$128**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$128
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$308

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA
265 Hegenberger Road, Suite 100
P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

July 20, 2018

To: All Active Participants and their Beneficiaries – Plan B and Flat Rate Plan

From: BOARD OF TRUSTEES
Carpenters Health and Welfare Trust Fund for California

Re: SUMMARY OF BENEFITS AND COVERAGE (SBC) required by the Affordable Care Act (ACA)

As required by law, group health plans like ours are providing plan participants with a Summary of Benefits and Coverage (SBC) as a way to help understand and compare medical benefits. The SBC provides a brief overview of the medical plan benefits provided by the Carpenters Health and Welfare Trust Fund for California. Please share this SBC with your family members who are also covered by the Plan.

Each SBC contains concise medical plan information in plain language about benefits and coverage. This includes what is covered, what you need to pay for various benefits, what is not covered, and where to go for more information or to get answers to questions. Government regulations are very specific about the information that can and cannot be included in each SBC. The Plan is not allowed to customize much of the SBC. An SBC includes:

- A health plan comparison tool called "Coverage Examples." These examples illustrate how the medical plan covers care for two common health scenarios: having a baby and diabetes care. These examples show the projected total costs associated with each of these two situations, how much of these costs the Plan covers and how much you, the participant, need to pay. In these examples, it's important to note that the costs are national averages and do not reflect what the actual services might cost in your area. Plus, the cost for your treatment might also be very different depending on your doctor's approach, whether your doctor is an In-Network PPO Provider or a Non-PPO Provider, your age and any other health issues you may also have. These examples are there to help you compare how different health plans might cover the same condition—not for predicting your own actual costs.
- A link to a "Glossary" of common terms used in describing health benefits, including words such as *"deductible," "co-payment,"* and *"co-insurance."* The glossary is standard and cannot be customized by a Plan.
- Websites and toll-free phone numbers you can contact if you have questions or need assistance with benefits.

Please keep this notice with your benefit booklet. If you have any questions, please call Benefit Services at the Trust Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.carpenterfunds.com or call 1-888-547-2054. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.carpenterfunds.com or call 1-888-547-2054 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Contract Provider: $128/individual per calendar year; $256/family per calendar year. Non-Contract Provider: $257/person per calendar year; $514/family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Mental health, chemical dependency (including detox), member assistance program visits, Contract Provider On-line physician visits up to $49 per visit, and outpatient prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	There is no out-of-pocket limit on all types of cost sharing, but there is a $6,445/person ($12,890/family) on the amount of coinsurance that you must pay for covered services in a year.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, hearing examination and hearing aid expenses, penalties for failure to obtain precertification, deductibles, expenses from Non-Contract providers, outpatient retail/mail order prescription drug expenses, amounts over the reference-based pricing allowances and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-888-547-2054 for a list of Contract providers in California. See www.bcbs.com or	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's

Important Questions	Answers	Why This Matters:
	call 1-800-810-2583 for a list of Contract providers outside the state of California.	charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Specialist visit	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Preventive care/screening/ Immunization	20% coinsurance	40% coinsurance	• For adults and children between ages 2 and 18, benefits are limited to one routine physical exam in any 12-month period. • You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. • Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Professional/physician charges may be billed separately (Services from Non-Contract providers not registered with CMS are limited to $100/appointment). Precertification is required for CT/CTA, MRI, Nuclear Cardiology, Pet Scans and Echocardiography.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call 1-800-939-7093.	Generic drugs	Retail: $15 copay/fill. Mail order: $26 copay/fill	You pay 100% (unless there are no network pharmacies within 10 miles). Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	• Retail Pharmacy – 30-day supply • Mail Order Pharmacy – 90-day supply • Deductible does not apply to outpatient prescription drugs. • Cost sharing for outpatient prescription drugs **does not count** toward the out-of-pocket limit. • If the cost of the drug is less than the copay, you pay just the drug cost. • Brand name Proton Pump Inhibitors (PPI) and Cholesterol drugs not covered. • For any new Brand Name Drug approved by the federal FDA, including injectable and infusion drugs, the copay is 50% of the cost of the drug for a minimum of 24 months after the drug has been approved. If the PBM determines that the new FDA-approved drug is a "must not add" drug, the copay will remain at 50% of the cost of the drug. • Mail Order is mandatory if more than 2 prescriptions are filled for maintenance medications.
	Preferred brand drugs (Formulary brand drugs)	Retail: $15 copay/fill + cost difference between generic and brand for multi-source brand. $53 copay/fill for single-source formulary brand. Mail order: $26 copay/fill + cost difference between generic and brand for multi-source brand. $106 copay/fill for single-source formulary brand.		
	Non-preferred brand drugs (Non-formulary brand drugs)	Retail: $80 copay/fill; Mail Order: $133 copay/fill		
	Specialty drugs	Subject to Retail Copays (30-day supply).	Not covered	Specialty drugs are available only from the PBM's Mail Order Pharmacy (except certain emergency drugs may be provided by a retail Participating Pharmacy).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance plus any amounts over $300	For the hospital facility charge, a maximum of $6,000 is payable for an arthroscopy, $2,000 for cataract surgery, $1,500 for colonoscopy, and $1,000 for endoscopy. Precertification is recommended for outpatient surgery.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	***Medical:*** 20% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 40% coinsurance (20% coinsurance if no choice in hospital due to emergency). ***Mental Health or Substance Abuse:*** No charge	Professional/physician charges may be billed separately. (Services from Non-Contract providers not registered with CMS are limited to $100/appointment).
	Emergency medical transportation	20% coinsurance	20% coinsurance.	Limited to emergency care or medically necessary inter-facility transfer to the nearest hospital, only. Services provided by an Emergency Medical Technician (EMT) without subsequent emergency transport are covered.*See Article 1 of the Plan Document for more information on emergency care.
	Urgent care	***Medical:*** 20% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 40% coinsurance (20% coinsurance if no choice in hospital due to emergency). ***Mental Health or Substance Abuse:*** No charge	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	• Precertification is required. • A maximum of $30,000 is payable for the hospital facility charges associated with a single hip joint or knee joint replacement surgery. • In a Non-Contract Hospital, the plan covers a room with 2 or more beds (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used). • Services from Non-Contract providers not registered with CMS are not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	***Mental Health:*** Office visit: No charge, deductible does not apply. Other outpatient services: 20% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply	40% coinsurance, deductible does not apply.	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Inpatient services	***Mental Health:*** 20% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply.	40% coinsurance, deductible does not apply.	• Precertification is required. • In a Non-Contract Hospital, the plan covers a room with 2 or more beds (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used) • Services from Non-Contract providers not registered with CMS are not covered.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	• Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). • Services from Non-Contract providers not registered with CMS are limited to $100/appointment
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Precertification is required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. Services from Non-Contract providers not registered with CMS are not covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Rehabilitation services	20% coinsurance	40% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $100/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered.
	Habilitation services	Not covered	Not covered	You pay 100% for this service, even in-network.
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification is recommended. Limited to 70 days per confinement. Services from Non-Contract providers not

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
				registered with CMS are not covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental covered up to reasonable purchase price.
	Hospice services	20% coinsurance	40% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $100/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered. Covered if terminally ill. Respite care is limited to 8 days.
If your child needs dental or eye care	Children's eye exam	$10 copayment	$10 copayment	Vision benefits are available through a separate vision plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	$25 copayment, plus all amounts over $150 for frames	$25 copayment, plus all amounts over $35 for single vision lenses and amount over $45 for frames	
	Children's dental check-up	No charge, a deductible does not apply to these services.		Limited to $2,500/person for Contract and $2,000/person for Non-Contract per calendar year. Dental benefits are available through a separate dental plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (up to $35/visit and 20 visits per calendar year)
- Bariatric surgery (with precertification)
- Chiropractic care (Employee and spouse only. Up to $25/visit up to 20 visits per calendar year)
- Dental care (Adult) (up to $2,500 for Contract and $2,000 for Non-Contract per calendar year)
- Hearing aids (limited to $800/ear in any 3-year period)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (under separate vision plan)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Trust Fund Office at 1-888-547-2054. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-547-2054.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-547-2054.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-547-2054.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$128**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$128
Copayments	$90
Coinsurance	$2,490
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$2,718

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$128**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$128
Copayments	$580
Coinsurance	$570
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,338

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$128**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$128
Copayments	$0
Coinsurance	$360
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$488**

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100 ✧ P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

July 20, 2018

To: **All Active Participants and Dependents of the Carpenters Health and Welfare Trust Fund for California, including COBRA Beneficiaries**

From: **Board of Trustees**

Re: **Notice of Creditable Coverage**
Important Information about Medicare Prescription Drug Program (Part D)

This notice is for people with Medicare or who may become eligible for Medicare.
Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with Carpenters Health and Welfare Trust Fund for California and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members <u>are not now eligible for Medicare</u>, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members <u>are now eligible for Medicare or may become eligible</u> for Medicare in the next 12 months, you should read this Notice very carefully.**

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

<u>The Trust Fund has determined that the prescription drug coverage under the Carpenters Health and Welfare Trust Fund for California – Indemnity Medical Plan (as administered by Express Scripts) and the Kaiser Plan for Active Employees and Non-Medicare Retirees are "creditable." (the Kaiser Senior Advantage is an actual Medicare Part D plan and this notice does not apply to Participants who are covered by this plan.)</u>

Coverage is "Creditable" if the value of this Plan's prescription drug benefit equals or exceeds the value of the standard Medicare prescription drug coverage. In other words, the benefit is, on average for all plan participants, expected to pay out as much or more than the standard Medicare prescription drug coverage will pay.

Because the Plan option(s) noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can keep your prescription drug coverage under the Carpenters Health and Welfare Trust Fund for California Indemnity Medical Plan, and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment penalty).

REMEMBER TO KEEP THIS NOTICE

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following three (3) times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months, and at other times in the future such if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage, you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 continuous days or longer without creditable prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE YOUR CHOICES?

You can choose either **one** of the following options:

OPTION 1

What you can do:
You can select or keep your current prescription drug coverage with Carpenters Health and Welfare Trust Fund for California Indemnity Medical Plan, and **you do not have to enroll in a Medicare prescription drug plan.**

What this option means to you:
You will continue to be able to use your prescription drug benefits through Carpenters Health and Welfare Trust Fund for California Indemnity Medical Plan.

- You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15 through December 7 of each year).
- As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment penalty) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.

OPTION 2

What you can do:
This option applies to Indemnity Medical Plan members only. You can select or keep your current Indemnity medical and prescription drug coverage with Carpenters Health and Welfare Trust Fund for California **and also enroll in a Medicare prescription drug plan.**

You will need to pay the Medicare Part D premium out of your own pocket.

What this option means to you:
For Indemnity Medical Plan Members Only: Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, and you are in the Indemnity Medical Plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under the Indemnity Medical Plan and Medicare means that you will still be able to receive all your current health coverage and this Plan will coordinate its drug payments with Medicare. This group health plan pays primary and Medicare Part D coverage pays secondary.

Note that you may not drop just the prescription drug coverage under the Indemnity Medical Plan of the Carpenters Health and Welfare Trust Fund for California. That is because prescription drug coverage is part of the entire medical Plan.

Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:

- PDPs may have different premium amounts;
- PDPs may cover different brand name drugs at different costs to you;
- PDPs may have different prescription drug deductibles and different drug copayments;
- PDPs may have different networks for retail pharmacies and mail order services.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help. (See your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Para mas información sobre sus opciones bajo la cobertura de Medicare para recetas medicas.

Revise el manual "Medicare Y Usted" para información detallada sobre los planes de Medicare que ofrecen cobertura para recetas medicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben de llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deben de llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Contact: Benefit Services Department
Carpenters Health and Welfare Trust Fund for California
Address: 265 Hegenberger Road, Suite 100, Oakland, CA 94621
Phone Number: (888) 547-2054

As in all cases, the Carpenters Health and Welfare Trust Fund for California and, when applicable, the insurance companies of the insured medical plan options offered by the Trust Fund reserves the right to modify benefits at any time, in accordance with applicable law. This document dated **July 20, 2018** is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100 ✧ P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

July 20, 2018

To: **All Active Participants and Dependents of the Carpenters Health and Welfare Trust Fund for California, including COBRA Beneficiaries**

From: **Board of Trustees**

Re: **Important Information about Your Medical Plan**

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN YOUR HEALTH PLAN

Certain entities, including the trustees of a group health plan, are required by law to collect the Taxpayer Identification Number (TIN) or Social Security Number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. These entities are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a Social Security Number, visit http://www.socialsecurity.gov/online/ss-5.pdf for the form to request a SSN. Applying for a Social Security Number is FREE.

If you have not yet provided the Social Security Number (or other TIN) for each of your dependents enrolled in the health plan, please contact the Fund Office at (510) 633-0333 or toll free at (888) 547-2054.

OPTION TO DECLINE DENTAL PLAN AND/OR VISION PLAN COVERAGE

In accordance with Health Reform regulations, you have the option to decline the Plan's dental and vision coverage. To decline coverage, complete the portion of the Plan's Enrollment Form related to declining dental plan and/or vision plan coverage. Enrollment Forms are available from the Fund Office.

- Note that there is no additional compensation to you if you choose to decline/waive dental and/or vision coverage.
- If you decline dental and/or vision coverage you may re-enroll for such coverage after 12 months has lapsed, by contacting the Fund Office. Changes to the enrollment in dental plan and/or vision plan coverage are permitted once each 12 month period.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI) REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Notice of Privacy Practices explains how the Carpenters Health and Welfare Trust Fund for California uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. To obtain another copy of this Notice write the Trust Fund Office in care of: HIPAA Privacy Officer, 265 Hegenberger Road, Suite 100, Oakland, CA 94621. You may also request a copy by calling (510) 633-0333, or toll free at (888) 547-2054 visiting our website at www.carpenterfunds.com, or emailing, benefitservices@carpenterfunds.com.

HIPAA Privacy Notices that pertain to the HMOs (prepaid medical and drug plans) may be obtained by contacting the HMO directly at the address provided in the Summary Plan Description or Evidence of Coverage, or by calling Kaiser at (800) 464-4000.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayments, and coinsurance applicable to other medical and surgical benefits under the various medical plans offered by the Carpenters Health and Welfare Trust Fund for California. For more information on WHCRA benefits, contact the Trust Fund Office or your medical plan directly at one of the following phone numbers:

Kaiser: 1(800) 464-4000
Indemnity: 1(888) 547-2054 (Claims Department)

SPECIAL EXTENSION OF COVERAGE FOR CERTAIN DEPENDENT STUDENTS ON A MEDICALLY NECESSARY LEAVE OF ABSENCE – MICHELLE'S LAW

This only applies to children of a Domestic Partner and children who are covered as a result of legal guardianship and must be full-time students in order to be covered after age 19.

If you have a dependent child that is over the age of 18 and is enrolled in a post-secondary institution (i.e. college or university) and the Plan receives a written certification from a covered child's treating physician that:

(1) the child is suffering from a serious illness or injury, and
(2) a leave of absence (or other change in enrollment) from a post-secondary institution is medically necessary, and the loss of postsecondary student status would result in a loss of health coverage under the Plan, then

the Plan will extend the child's coverage for up to one year.

This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the **earlier** of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan. Contact the Trust Fund Office at (510) 633-0333 or toll free at (888) 547-2054 for more information.

HOSPITAL LENGTH OF STAY FOR CHILDBIRTH

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician, after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization.

DISCLOSURE OF "GRANDFATHERED" STATUS

This group health Plan believes that the Fund's Indemnity Medical Plan is considered to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage already in effect when that law was enacted.

Being a grandfathered health plan means that certain consumer protections of the Affordable Care Act that apply to other plans may not be required. For example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at (510) 633-0333 or Toll Free at (888) 547-2054. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT (ENROLLED IN THE KAISER PLANS ONLY)

The Kaiser medical plan generally allows the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at 1-800-464-4000. Medicare Advantage Plans are subject to many of their own requirements, be sure to contact Kaiser at 1-800-464-4000 for more information about your Medicare Advantage Plan.

DIRECT ACCESS TO OBSTETRICAL / GYNECOLOGICAL PROVIDERS (KAISER PLANS ONLY)

You do not need prior authorization (pre-approval) from Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser at 1-800-464-4000. Medicare Advantage Plans are subject to many of their own requirements, be sure to contact Kaiser at 1-800-464-4000 for more information about your Medicare Advantage Plan.

REPORTING REQUIREMENTS UNDER THE AFFORDABLE CARE ACT

As required by the Affordable Care Act, each year, you will receive an IRS form (called Form 1095-B) in the mail if you or your dependents have been covered under a medical plan during the year. For each month of the calendar year that you were enrolled in a medical plan, Form 1095-B documents that you (and any enrolled family members) met the federal requirement to have “minimum essential coverage,” meaning group medical plan coverage. Having minimum essential coverage means you and your family members may not have to pay a penalty (called the Individual Mandate penalty) when you file your personal income taxes. Visit the Health Insurance Marketplace at https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/ for detailed information on this penalty.

If you receive a 1095 form, you will want to keep this form in a safe place because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095 will also be provided to the IRS.)

Reminder: if you have not been covered by a medical plan during the last calendar year you will not receive a Form 1095-B. If you have been covered by various medical plans during the calendar year, you may receive more than one IRS form.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the following pages, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2018. Contact your State for further information on eligibility

ALABAMA – Medicaid	**ALASKA –** Medicaid	**ARKANSAS -** Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA** – Medicaid	**GEORGIA** – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

INDIANA – Medicaid	**IOWA** – Medicaid	**KANSAS** – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 1-800-403-0864	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://www.kdheks.gov/hcf/ Phone: 785-296-3512
KENTUCKY – Medicaid	**LOUISIANA** – Medicaid	**MAINE –** Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA** – Medicaid	**MISSOURI** – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA** – Medicaid	**NEVADA** – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Medicaid Website :https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY** – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA** – Medicaid	**OKLAHOMA** – Medicaid and CHIP
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA** – Medicaid	**RHODE ISLAND** – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA** - Medicaid	**TEXAS** – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT**– Medicaid	**VIRGINIA** – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Medicaid and CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid	**WEST VIRGINIA** – Medicaid	**WISCONSIN** – Medicaid and CHIP
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473	Website: http:// mywvhipp.com/ Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid		
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531		

To see if any other States have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

SUMMARY ANNUAL REPORT FOR
CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Plan Year – September 1, 2016 through August 31, 2017

This is a summary of the annual report for the Carpenters Health and Welfare Trust Fund for California, Employer Identification Number 94-1234856, a health and welfare plan, for the period September 1, 2016 through August 31, 2017. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California has committed the Fund to pay Medical, Hospital, Dental, Orthodontia, Prescription Drug, Vision, Hearing Aid, Physical Examination, Weekly Disability, Mental Health and Substance Abuse claims under the terms of the Plan.

Insurance Information:

The Plan has contracts with Kaiser Foundation Health Plan, Inc., and Health Net to provide medical and hospital coverage, Voya Financial, Inc. to provide accidental death, dismemberment, and life insurance benefits, and AIG Benefits Solutions to provide stop loss coverage. The total premiums paid for all contracts for the Plan year ending August 31, 2017 were $274,805,956.

Basic Financial Statement:

The value of Plan assets, after subtracting liabilities of the Plan, was $577,137,049 minus premiums and self-funded claims payable of $80,816,087, minus claims incurred but not reported of $11,916,000, minus bank of hours liability of $163,122,000, equals $321,282,962 as of August 31, 2017, compared to $491,739,264 minus premiums and self-funded claims payable of $71,572,054, minus claims incurred but not reported of $10,819,000, minus bank of hours liability of $142,368,000, equals $266,980,210 as of September 1, 2016. During the Plan year, the Plan experienced an increase in its net assets of $54,302,752. This increase included unrealized appreciation or depreciation in the value of Plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year.

The Plan had total income of $490,860,871; including employer contributions of $415,731,400, participant contributions of $24,870,139, a gain of $1,722,942 from the sale of assets, earnings from investments of $32,611,825, and other income of $15,924,565.

Plan expenses were $436,558,119. These expenses included $12,575,552 in administrative expenses, $1,318,716 in investment expenses, $274,805,956 in premium costs, and $147,857,735 in self-funded benefits paid directly to participants and beneficiaries or to service providers on their behalf.

Condensed Financial Statement

Beginning Balance Value of Net Plan Assets	**As of 9/01/2015 $233,692,912**	**As of 9/01/2016 $266,980,210**
Employer Contributions	$373,224,435	$415,731,400
Participant Contributions	$24,589,405	$24,870,139
Investments - Earnings	$22,176,793	$32,611,825
Sale of Assets - Earnings/Losses	-$327,739	$1,722,942
Other Income	$12,481,667	$15,924,565
Plan Income	**$432,144,561**	**$490,860,871**
Insurance Premiums	$232,200,029	$274,805,956
Self-Funded Benefits	$152,915,545	$147,857,735
Administrative Fees	$12,630,095	$12,575,552
Investment Expenses	$1,111,594	$1,318,876
Total Expenses	**$398,857,263**	**$436,558,119**
Ending Balance Value of Net Plan Assets	**As of 08/31/2016 $266,980,210**	**As of 08/31/2017 $321,282,962**

Your Rights to Additional Information:

You have the right to receive a copy of the full annual report, or any part thereof, on request. The following items are included in that report: 1) An accountant's report, 2) Insurance information including sales commission paid by insurance carriers, 3) Assets held for investments; and 4) Transactions in excess of five percent of Plan assets.

Obtaining Copies of a Summary Annual Report:

The report provided is a summary of the annual report filed for the Carpenters Health and Welfare Trust Fund for California. To obtain a copy of the full annual report or any part thereof, write or call the Carpenter Funds Administrative Office of Northern California, Inc., which is the Fund Manager appointed by the Plans' Administrator, at 265 Hegenberger Road, Suite 100, Oakland, California 94621; telephone (888) 547-2054. The charge to cover copying costs will be $15.00 per full annual report, or $.25 per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the Plan and accompanying notes, or both. If you request a copy of a full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the Plan, located at 265 Hegenberger Road, Suite 100, Oakland, California 94621 and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor (upon payment of copying costs). Requests to the Department of Labor should be addressed to: Public Disclosure Room, N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

AVISO

Si usted tiene dificultad en entender alguna parte de este folleto, comuníquese con Carpenter Funds Administrative Office en 265 Hegenberger Road, Suite 100, Oakland, CA 94621. Las horas de oficina son de 8:00 a.m. a 5:00 p.m., lunes a viernes. Usted también puede llamar a la oficina del Plan, teléfono 888-547-2054, para ayuda.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100 ✧ P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

August 3, 2018

TO: All Active Plan Participants and their Dependents, including COBRA Beneficiaries (Plans A, B, R, and Flat Rate)

FROM: BOARD OF TRUSTEES
Carpenters Health and Welfare Trust Fund for California

RE: Changes to Disability Claim and Appeal Procedures
Changes to Certain Indemnity Plan Benefits

- **Insulin Pen Products**
- **Hearing Exams**
- **Contact Lenses**
- **Routine Physical Exam**

This Participant Notice will advise you of certain material modifications that have been made to your medical benefits for covered services. This information is important to you and your Dependents. Please take the time to read it carefully.

The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California modified the Plan Rules and Regulations for Active Participants and Dependents as follows:

CLAIMS AND APPEALS PROCEDURES FOR CERTAIN DISABILITY CLAIMS Filed on or after April 1, 2018:

The Department of Labor issued new regulations, which provide disability benefit claimants with greater protections for Disability claims under the Plan's Disability Extension benefit or Supplemental Weekly Disability benefit in limited circumstances. The new regulations apply when you reside in a state that does not provide a State Disability Insurance (SDI) benefit and your Physician provided a statement of your disability but the Plan nonetheless, denied your request for a Disability benefit.

The following is a brief description of each of the requirements that may impact you:

1) ***Right to Review and Respond to New Information before Final Decision on a Review of a Denied Claim:*** You have a right to review and respond, in writing or by presenting testimony, to new evidence and rationales considered, relied upon, or generated by the Plan or at the Plan's direction while an appeal is pending (free of charge). This new evidence and/or rationale will be provided to you automatically, as soon as possible, and sufficiently before the deadline for you to file your notice to appeal. The Fund will allow you a reasonable opportunity to respond to new information by presenting written evidence and testimony. Disability claims will be decided within 45 days.

2) ***Deemed Exhaustion of Claims and Appeals Processes:*** If the Fund makes an error with respect to following the new regulations discussed in this Notice, you may be able to file a lawsuit in court immediately, instead of going through the Fund's normal claims procedures (known legally as "exhausting your administrative remedies"). Your claim is legally deemed as denied by the Fund in that instance. You will not be deemed to have exhausted your administrative remedies, and must therefore go through the Fund's normal procedures if: (a)

the Fund's violation was *de minimis* (minor in nature) and did not cause prejudice or harm to you; (b) the violation was for good cause or due to matters beyond the control of the Fund; and (c) the violation occurred in the context of an ongoing, good faith exchange of information between the Fund and you, the claimant.

3) ***Enhanced Disclosure Requirements for Benefit Denial Notices (Both Adverse Determination and Appeal Denial):*** Disability benefit determinations disability benefit denials notices on appeal require, and will include, the following additional information:

   - A statement that you, the claimant, are entitled to receive access to and copies of all relevant documents upon request and without charge.
   - A discussion of the decision, including the basis for disagreeing with or not following the views of a treating physician or vocational professional, the views of medical or vocational experts obtained by the Fund, or a disability determination by the Social Security Administration.
   - If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination as applied to the claimant's medical circumstances will be provided free of charge upon request.
   - The internal rules, guidelines, protocols, standards or other similar criteria the Fund relied on in denying the claim, or a statement that none exist.

   In addition, disability benefit denial on appeal notices require a description of any applicable contractual limitation periods and their expiration dates, in addition to the description of the claimant's right to bring an action under ERISA Section 502(a).

4) ***Notices Must be Provided in Culturally and Linguistically Appropriate Manner:*** The Fund must provide disability denial notices in a culturally and linguistically appropriate manner if your address is in a county where 10% or more of the population residing in that county are literate only in the same non-English language. In such situations, disability denial notices must:

   - Include a prominent one-sentence statement in the relevant non-English language about the availability of language services.
   - Provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language.
   - Provide written notices in the non-English language upon request.

5) ***Conflict of Interest:*** Reviews of disability claims require a process that ensures independence and impartiality among decision-makers. Claim decisions may not be linked to the hiring, compensation, termination, promotion, or other similar matters related to decision-makers (e.g., bonuses based on benefit denials). In addition, the Fund will not contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than on his or her professional qualifications.

6) ***Coverage Rescissions:*** Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (*e.g.,* errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the plan's appeals procedures. This would be the case even if the affected participant was not receiving disability benefits at the time of the rescission. Retroactive terminations for non-payment of premiums are not covered by this provision.

INDEMNITY PLAN BENEFIT CHANGES

INSULIN PEN PRODUCTS

Beginning September 1, 2018, the Fund will no longer require preauthorization for insulin pen products. Medically necessary formulary insulin pen products will be covered by the Plan the same as any other covered outpatient prescription drug, subject to applicable outpatient drug copayments and all other applicable Plan provisions.

HEARING EXAMS

Effective January 1, 2018, the Fund will cover hearing exams when ordered by a Physician. Hearing exams will be paid by the Plan at 90% (Plan A and R) or 80% (Plan B or Flat Rate), following satisfaction of the calendar year Deductible for Contract Providers. The Plan will pay 70% (Plan A and R) or 60% (Plan B or Flat Rate) of Allowed Charges, following satisfaction of the calendar year Deductible for Non-Contract Providers. Hearing exam cost-sharing, when applicable, will apply to the Coinsurance Maximum.

To be eligible for coverage, the hearing exam must be medically necessary and performed by a Physician or healthcare practitioner with a master's or doctoral degree in audiology.

The Plan's coverage of hearing aids is otherwise unchanged, and continues to be limited to a maximum payment of $800 per ear in any 3-year period for the covered costs of hearing aids, repairs and servicing combined.

CONTACT LENSES

Beginning September 1, 2018, the Fund will increase the benefit for contact lenses and pay up to a $130 retail allowance for elective contact lenses and fitting and evaluation exam combined. This benefit will continue to be limited to once every 12 months, and is in lieu of any benefit for eye glasses (frames and lenses), and subject to any other applicable Plan provisions. As a reminder, when contact lenses are obtained, you will not be eligible for regular spectacle lenses again for 12 months and frames for 24 months.

ROUTINE PHYSICAL EXAM BENEFIT

Effective August 1, 2017, the Fund covers routine physical examinations for Dependent children of any age. This benefit will continue to be limited to one physical exam in any 12-month period, and subject to normal plan benefits including Deductible and Coinsurance.

* * * * *

Because this Plan is a "grandfathered health plan," we are required by law to provide this notice to you:

Grandfathered Health Plan: The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California believes the Indemnity Medical Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination

of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator or the Department of Labor at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.carpenterfunds.com.

The Board of Trustees maintains the right to change or discontinue the types and amounts of benefits under this Plan. This notice is intended as a summary only, and actual Plan documents will be used to interpret the Plan. Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. No individual Trustee, Employer or Union Representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.