

## IMPORTANT NOTICE TO UA LOCAL 38 MEMBERS AND THEIR DEPENDENTS AND RETIREES

The Board of Trustees of the U.A. Local 38 Health & Welfare Trust Fund (“the Trust Fund”) is pleased to present this fully updated *Summary Plan Description* which describes the health and welfare benefit plans for both active and retired employees.

This booklet is both the *Summary Plan Description* (your “SPD”) and Plan Document required by the Employee Retirement Income Security Act of 1974 (“ERISA”). Note that if you have Health Net or Kaiser HMO coverage instead of the medical benefits described in this booklet, you also receive an *Explanation of Coverage* (“EOC”) from Health Net or Kaiser. That EOC is considered part of, and should be kept with, this SPD.

Please read this information carefully and share it with your family. It is intended to be your primary resource for information about your health and welfare benefits. From time to time the Board of Trustees may find it necessary to change the provisions of the Plan. When this occurs, you will be notified.

If you need additional information about your benefits, you may contact the Administration Trust Fund Office (“the Trust Fund Office”) by telephone at (415) 626-2000. As a convenience to you, the Trust Fund Office will provide oral answers on the telephone on an informal basis. However, the answers supplied by the Trust Fund Office are not binding on the Board of Trustees, which has sole discretion to interpret and apply the Plan. *Only the Board of Trustees is authorized to interpret the Plan described in this booklet and no individual Trustee, employer or union representative is authorized to interpret the Plan on behalf of the Board or to act as an agent of the Board.*

This document does not serve as a guarantee of continued employment or benefits. The Board of Trustees reserves the right to change, reduce or terminate this or any of the Trust Fund’s benefits plans at any time. **The benefit programs and policies described in this booklet are current as of May 1, 2009, unless specifically stated otherwise.** From time to time the Trust Fund Office may mail you updated material in order to inform you and your Dependents of any changes in benefits. Please read that information carefully and keep it with this booklet.

### FOREIGN LANGUAGE NOTICE

This booklet contains a summary in English of your rights and benefits under the U.A. Local 38 Health & Welfare Plan. If you have any difficulty in understanding any part of this booklet, you may contact the U.A. Local 38 Health & Welfare Trust Fund Administration Office, 1625 Market Street, San Francisco, CA 94103, or call (415) 626-2000.

### AVISIO EN ESPAÑOL

**Este folleto contiene un resumen en ingles de sus derechos y beneficios bajo el U.A. Local 38 Health & Welfare Plan. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con U.A. Local 38 Health & Welfare Fund Administration Office, 1625 Market Street, San Francisco, CA 94103, o llamar a los teléfonos (415) 626-2000.**

Yours very truly,

Larry Mazzola, Jr.  
Chairman

Scott Strawbridge  
Co-Chairman



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# YOUR CHOICE OF HEALTH PLAN

All eligible employees have the opportunity to choose between the U.A. Local 38's Health Net PPO Health Plan, the Health Net HMO Health Plan or the Kaiser Foundation Health Plan. Your choice of medical Plan applies to you and all of your Dependents. All members of your family must be covered in the same medical Plan. Once having made your decision, you may change Plans only during the annual open enrollment held during the months of May and June (for a coverage change effective July 1).

If you or your Dependent is hospital confined on the date your coverage under the medical Plan you have chosen is to start, you must notify the Health Plan (at the phone number listed on page 62). If you are new to the U.A. Local 38 Health & Welfare Plan and you were not covered by another group health plan immediately before your U.A. Local 38 Health & Welfare Plan coverage begins, you may be subject to a pre-existing condition exclusion. If you think that you may be subject to a pre-existing condition, call the medical Plan you have selected at the number listed on page 62 to inform them that you or a Dependent are hospitalized.

To enroll in one of the three Plans, you must complete an Enrollment/Change Form which will be furnished to you by the Trust Fund Office.

This booklet is divided into the following six parts:

- Medical Benefits**
  - Health Net PPO Health Plan
  - Health Net HMO Health Plan
  - Kaiser Foundation Health Plan
- Prescription Benefits**
  - Envision Rx Program
- Dental Benefits**
  - Delta Dental Program
- Vision Benefits**
  - Vision Service Plan
- Life, Accidental Death and Dismemberment Insurance Benefits**
- Overview of Plan Terms and Other Plan Provisions**

Whether you choose the Health Net PPO Health Plan, or one of the HMO Plans, the same Prescription, Dental, Vision, and Life Insurance Benefits described in this booklet apply to *all* Plan participants.

The **Health Net PPO** plan is a traditional health plan that covers doctor and hospital bills for treatment of illness or injury. You may go to any In-PPO-Network licensed physician or hospital you choose and all claims incurred will be paid. However, should you choose an Out-of-PPO Network physician or hospital, that is a physician or hospital not listed in Health Net's PPO Provider Listing, you may be responsible for a portion of the treatment cost (see page 27). In accordance with the schedules described in this handbook, the Plan pays specific amounts toward services rendered.

The **Health Net HMO** and **Kaiser Foundation HMO** are prepaid designed to treat illness and injury but also to maintain health by covering preventative care that may not be available under the PPO Plan. However, under Health Net's HMO, you must receive your treatment at a Health Net HMO hospital and from HMO physicians. If you choose the Kaiser Foundation HMO Plan you must receive treatment in a Kaiser facility. However, both the Health Net and the Kaiser HMO Plans allow you to choose a personal physician from their provider lists.

# ELIGIBILITY RULES

Even if you have satisfied all of the Plan eligibility rules, you will not be covered until you have submitted a fully completed Enrollment Form to the Trust Fund Office. Enrollment Forms are available at the Trust Fund Office located at 1625 Market Street, San Francisco, CA 94103. *Services may be delayed or denied to you or your dependents that are not properly enrolled.*

## ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

### Initial Eligibility

An Active Participant becomes eligible for coverage on the first (1<sup>st</sup>) day of the second (2<sup>nd</sup>) month after having worked 220 hours or more in a twelve (12) month period for an employer obligated to contribute to the U.A. Local 38 Trust Funds (provided your employer has timely made its contributions for your hours to the U.A. Local 38 Trust Funds). However, if you are not actively working for a contributing employer (or available for work for a contributing employer) on what would otherwise be your initial eligibility date, your Initial Eligibility date will be the date you first become actively employed for a contributing employer.

Example: In the month of January you work 90 hours under a U.A. Local 38 Collective Bargaining Agreement that provides for participation in the U.A. Local 38 Trust Funds. In February you work 70 hours and in March you work 80 hours for a total of 240 hours. Your employers timely submit reports and have paid contributions to the U.A. Local 38 Trust Funds, on your behalf, for the 240 hours (within the required twelve (12) month period). Your Initial Eligibility date would be the first (1<sup>st</sup>) day of the second (2<sup>nd</sup>) month after you have met the initial eligibility requirements: You satisfied the hours requirement in April, so the first (1<sup>st</sup>) day of the second (2<sup>nd</sup>) month after that is June. Your Initial Eligibility date would be June 1, if you are actively working for (or available to work for) a contributing employer as of that date.

### Coverage from Month to Month After You Have Established Initial Eligibility

After you have established Initial Eligibility your coverage will continue from month to month thereafter if you satisfy at least one of the following requirements:

- **You Continue Working Sufficient Hours.**

Coverage continues if you work a **minimum of 110 hours per month** for an employer obligated to contribute to the U.A. Local 38 Trust Funds and those contributions are timely paid to the Trust Funds. Eligibility is based on a “**lag month**” which means that hours worked in January, paid into the Trust Fund by your employer in February are credited for purposes of your continued eligibility in the Plan in March. In this example, February is the “lag month.”

- **You Don’t Work at Least 125 Hours During the Prior Month But Have Enough Reserve Hours to Make Up the Shortfall.**

After you have met your Initial Eligibility requirements, all hours contributed on your behalf in excess of the 110 minimum hours required for coverage for each month will be deposited into your “**Reserve Account**” (otherwise known as your “**hour bank**”). You can accumulate a maximum of 660 hours in your reserve account. If the contributions made to the U.A. Local 38 Trust Funds, on your behalf, in any month are less than the minimum 110 hours necessary for

continuous coverage the Trust Fund will deduct sufficient hours accumulated in your Reserve Account to bring the total hours up to 110 hours.

▪ **You Don't Have Enough Hours in Your Reserve Account But You Borrow Enough to Make Up the Shortfall.**

If you, as an active participant, have **80** or more hours in employer contributions in his Reserve Account, but less than the required 110 hours, you may apply for the additional hours necessary to bring your total hours up to the 110 hours required to maintain continuous coverage. *However, you may apply for these additional hours for no more than three (3) months in any Plan Year.*

▪ **You Qualify for Extended Coverage Due to Disability.**

An active participant who,

- (1) has been covered by the Plan for at least six (6) of the twelve (12) months preceding the disability;
- (2) becomes disabled and unable to work because of sickness or accident during a month that he/she has coverage; and
- (3) because of this sickness or accident, his/her Reserve Account falls below 110 hours;

may apply for the hours necessary to bring your total hours up to the 110 hours necessary to maintain continuous coverage. *However, you may do so for no more than six (6) months in any Plan Year.* Your Reserve Account must fall below 110 hours before this extension applies. Please note that disability health coverage months are not calculated towards this extended coverage.

▪ **Exercising Your COBRA Rights.**

Active participants who lose coverage as a result of a COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) "qualifying event" can continue coverage by self payment (see "COBRA Coverage" below).

**IF AT LEAST ONE OF THE ABOVE DOES NOT APPLY, YOUR COVERAGE AND YOUR DEPENDENTS' COVERAGE WILL END AS OF THE LAST DAY OF THE MONTH OF THE LAST MONTH IN WHICH YOU HAD AT LEAST 110 HOURS IN YOUR RESERVE ACCOUNT.**

**ELIGIBILITY RULES FOR DEPENDENTS OF ACTIVE PARTICIPANTS**

Your eligible Dependents' Initial Eligibility Date is the same date as the active participant's Initial Eligibility Date. Dependents eligible for coverage are limited to the following:

- Your lawful spouse (marriage certificate is required as proof).
- Your unmarried children (including a stepchild, legally adopted child, child placed with you for adoption, dependent children of your covered Domestic Partner, or child for whom you are the legal guardian) under nineteen (19) years of age who are listed as dependents on the participant's latest federal Income Tax Return, or any dependent named in a QMCSO (see page 5 below). For Life Insurance only, Dependent eligibility begins at age fourteen (14) days. NOTE: Foster children covered by the Plan on or before July 1, 2008 are also eligible for coverage for as long as they meet the Plan's eligibility rules.

- Your unmarried children who are at least nineteen (19) years of age and **less than twenty-six (26) years of age**, if wholly dependent on you for support and maintenance while attending school full-time. “Full-time” for this purpose is defined as a Dependent taking at least twelve (12) units per semester at the school or college they are attending. **The Plan requires proof of full-time student status every semester.**
- Your Dependent child who became disabled while covered by the Plan as a Dependent. This coverage will continue so long as the child is ineligible for Medicare, remains disabled, unmarried and dependent on you for support and maintenance. Proof of the continued existence of the child’s disability may be required periodically. For Life Insurance only, disabled children incapable of self support who are enrolled as Dependents before their 19th birthday may continue as Dependents until the earlier of age 21 or the date he/she is capable of self support, whichever occurs first.
- Your Domestic Partner.

#### **ELIGIBILITY FOR DOMESTIC PARTNERS**

A Domestic Partner is qualified for coverage as your Dependent if,

- You have a *Certificate of Domestic Partnership*, naming him or her as your Domestic Partner issued by the State of California; or
- You have a *Certificate of Domestic Partnership* naming him or her as your Domestic Partner issued by the City of San Francisco.

However, **the Plan does not cover opposite sex domestic partners unless your employer is required to provide such coverage by state or local law.**

Your Domestic Partner is eligible for coverage to the same extent coverage is available to a legal spouse. However, federal tax laws require the Trust Fund to determine how much of the hourly health & welfare employer contribution is attributable to the coverage of your Domestic Partner and to report that amount as additional taxable income paid to you. This additional taxable income applies unless you can show the Trust Fund that for purposes of your federal Income Tax Returns, you and your Domestic Partner reside in the same household and you have primary responsibility for your Domestic Partner’s living expenses. In other words, if your Domestic Partner has a job or supports himself or herself through his or her own work, you will have to pay the employee payroll taxes each quarter on part of the hourly employer health & welfare contribution paid on your behalf. The amount of the monthly employer contribution deemed “income” will be calculated by the Trust Fund once a year and is likely to be 40% or more of the monthly cost of coverage.

If your Domestic Partner is not your “dependent” for federal Income Tax purposes, the “additional income” described above is also subject to *employer* withholding. For your Domestic Partner to be covered your employer must pay the employer payroll taxes on the value of your Domestic Partner coverage and collect the employee payroll taxes attributable to your Domestic Partner’s coverage from your wages. If you want to enroll a Domestic Partner, call the Trust Fund Office.

## **ELIGIBILITY RULES FOR RETIREES**

If you meet the following eligibility rules you are eligible for the U.A. Local 38 Health & Welfare Retiree Health Plan (“Retiree Plan”). However, your benefits under the Retiree Plan (and the benefits of your eligible Dependents) are based on your age.

Retirees *under* age 65 (or otherwise ineligible for Medicare) are eligible for the medical and prescription drug benefits described in this booklet without a required co-contribution, and may self-pay for continued dental and vision coverage. Retirees age 65 or older (and their eligible Dependents) are covered only under the Plan’s prescription drug benefits. A Retiree’s spouse’s eligibility for benefits coverage is based on the age of the Retiree. So if the Retiree is age 65 or older, like you, your spouse’s coverage is limited to prescription drugs. Spouses are covered subject to monthly co-contributions. Dependent children are not eligible for Retiree coverage.

You are eligible for coverage as a Retiree if you meet each of the following requirements:

- You are under age 65;
- You are collecting a pension from the U.A. Local 38 Pension Trust Fund;
- You were covered under the U.A. Local 38 Health & Welfare Plan as an active participant for at least one (1) month within twelve (12) months prior to your retirement effective date; and
- You are a member of U.A. Local 38.

## **ELIGIBILITY FOR DEPENDENT CHILDREN COVERED UNDER A “QMCSO”**

A Qualified Medical Child Support Order (“QMCSO”) is a child support order which the Trust Fund has determined to be qualified that creates, recognizes or assigns a child’s right to receive benefits as your covered Dependent. When a QMCSO providing for coverage of a child as your Dependent is submitted to the Trust Fund, the Trust Fund will review the Order to determine whether it satisfies the legal requirements for a QMCSO (in other words, whether it is “*qualified*”). A medical child support order is not qualified unless it includes at a minimum all of the following:

- Name and last known address of the parent who is covered under this Plan,
- Name and last known address of each child to be covered under this Plan,
- A description of the type of coverage to be provided to each child named in the Order, and
- The period of time the coverage is to be provided to each child.

QMCSOs should be sent to the Trust Fund Administrator. If you do not enroll your child as required by the QMCSO, the Trust Fund Administrator will do so when a valid QMCSO is received. The child named in the QMCSO will be enrolled in the Plan option you are enrolled in, unless the QMCSO specifies a particular option.

If you are not enrolled in the Plan, but a Qualified Medical Child Support Order is entered which requires you to provide support to your child, if you are otherwise eligible, the Trust Fund will enroll you and the child named in the QMCSO.

You may not drop health care coverage for children covered by a QMCSO unless you submit written evidence that the QMCSO is no longer in effect.

### **HOW TO ENROLL IN THE PLAN**

Once you have established Initial Eligibility you will not be enrolled in the Plan until you have completed the Plan's Enrollment Form. You need to update your Enrollment Form whenever you change your address or add or drop a Dependent.

- **Spouse** – To enroll your spouse you must furnish a copy of your Marriage Certificate with the Plan's Enrollment Form. If you and your spouse divorce you need to provide the Plan with a copy of your Divorce Decree.
- **Dependent Children** – To enroll a dependent child you must provide the Plan with a copy of the Birth Certificate, adoption papers or Qualified Medical Child Support Order, whichever applies.
- **Students** – Dependent children are covered through age nineteen (19) and through age twenty-five (25) if enrolled as a full-time student. Students are also covered during the summer if they are registered to attend school full-time in the fall. You must submit proof of full-time student enrollment (which you can obtain from the school Registrar's Office).

### **TERMINATION OF COVERAGE**

**An Active Participant's** eligibility for benefits will terminate on the earliest of the following dates:

- The last day of the month following the month in which his/her hours worked and/or his/her reserve hours for coverage fall below 110 hours *and* there is no continuation by receipt of additional hours from the general fund for disability;
- Upon death.

**A Dependent of an Active Employee's** eligibility for benefits will terminate on the earliest of the following dates:

- When the employee's coverage terminates; or
- When the Dependent ceases to qualify as an eligible Dependent. If the employee fails to notify the Trust Fund that a Dependent is no longer eligible, **the employee will be liable for the re-payment of any claims paid on behalf of the ineligible Dependent.**

**A Retiree Plan Participant's** eligibility for benefits will terminate on the earliest of the following dates:

- For medical, dental and vision benefits, upon reaching Medicare eligibility or age sixty-five (65) (whichever is sooner);
- For dental and vision coverage, upon failure to timely pay your monthly co-contribution;
- Upon death.

**The Dependent of a Retiree Plan Participant's** eligibility for benefits will terminate as of the date the Retiree's eligibility terminates and the earliest of the following events:

- Failure to pay any required premiums;
- The Dependent reaches age sixty-five (65) and/or becomes eligible for Medicare (although prescription drug coverage will continue); or
- The Retiree's death.

**A Retiree Plan Participant's eligibility for the Prescription Drug Program** will terminate on the date the Retiree dies, upon enrollment in a Medicare Part D program outside of this Plan, or upon termination of the Program.

**A Dependent's eligibility for the Retiree Prescription Drug Program** will continue for a period of six (6) months from the date of the death of the Participant.

### **HIPAA Certificate of Coverage**

In accordance with the Health Insurance Portability Accountability Act of 1996 ("HIPAA"), when your coverage terminates through this Plan, you will receive a certificate that will show evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll.

### **REINSTATEMENT OF COVERAGE – ACTIVE EMPLOYEES AND DEPENDENTS**

If you are a participant in the Active Employee Plan and lose eligibility for the Plan but return to work within one (1) year of the date you were last covered, you are eligible for coverage on the first (1<sup>st</sup>) day of the second (2<sup>nd</sup>) month after your account contains at least 110 hours. However, if an Active Participant returns to covered employment more than one (1) year from the date you were last eligible, you must re-qualify as described in the Initial Eligibility section of this booklet.

### **COBRA CONTINUATION COVERAGE**

Under the federal Consolidated Omnibus Budget Reconciliation Act (commonly known as "COBRA"), you and/or your eligible Dependents may continue with the Trust Fund's health benefits upon the occurrence of certain "qualifying events" which would normally cause a termination of coverage. To receive this COBRA continuation coverage, you and/or your eligible Dependents must file a timely application following the qualifying event and make monthly self-payments directly to the Trust Fund Office.

### **COBRA "Qualifying Events" for Active Participants**

- If your hour bank falls below 110 hours or your eligibility terminates for any other reason, such as retirement, you and your eligible Dependents may elect COBRA continuation coverage for a maximum of **eighteen (18) months**.
- If the Social Security Administration determines that you or one of your eligible Dependents became totally disabled at any time before or during the first sixty (60) days of COBRA continuation coverage, the disabled person and family may extend COBRA coverage an **additional 11 months**, beyond the original eighteen (18), to a maximum of twenty-nine (29) months. To qualify for this disability COBRA extension you must

report and provide a copy of the Social Security Disability Determination to the Trust Fund Office before the initial eighteen (18) months of COBRA coverage expires and within sixty (60) days after the date of the Social Security determination.

When an Active Participant elects COBRA continuation coverage, he automatically continues eligibility for benefits for his eligible Dependents. If an Active Participant does not elect COBRA continuation coverage, each of his Dependents may elect such coverage independently. While a spouse's COBRA election will continue coverage for any covered dependent children.

Loss of coverage in the Retiree Plan for the Retiree is *not* a COBRA qualifying event for the Retiree (but may be for the Retiree's spouse, as explained below).

### **COBRA “Qualifying Events” for Dependents of Active and Retired Participants**

Your spouse, Domestic Partner, and eligible Dependent children may elect COBRA continuation coverage for a **maximum of thirty-six (36) months** from the loss of coverage resulting from any of the following qualifying events:

- Death of the Active Participant or Retiree;
- Divorce from the Active Participant or Retiree;
- A Dependent child of an Active Participant ceases to be eligible because he or she no longer meets the Trust Fund's definition of a “Dependent” because of age or student status.

A person continuing coverage under COBRA is known as a “qualified beneficiary.”

A child born to or placed for adoption with an Active Employee during a period of COBRA continuation coverage may be added immediately to COBRA coverage by notifying the Fund Office within thirty (30) days of the birth or adoption. These newborn or adopted children are considered qualified beneficiaries and will have the same COBRA rights as a spouse or child covered by the Plan before the qualifying event.

### **Second “Qualifying Events” for the Dependents of Active Employees**

If a second qualifying event occurs during the first eighteen (18) months of continuation coverage, or if the Active Participant becomes entitled to Medicare during that period, COBRA coverage may be extended for Dependents for up to thirty-six (36) months from the date of the first qualifying event.

Example: An Active Participant and his spouse's *first* COBRA qualifying event occurred because his Hour Bank fell below 110 hours. He timely elects COBRA continuation coverage, but during his first eighteen (18) months of COBRA coverage the Active Participant dies. His death is a second “qualifying event” and entitles his spouse to an additional eighteen (18) months of coverage (thirty-six (36) months maximum, the initial eighteen (18) months, plus an additional eighteen (18) months because of the second qualifying event – the Active Participant's death).

If an Active or Retired Participant becomes entitled to Medicare either (1) *after* electing COBRA coverage, eligible Dependents may continue coverage for up to thirty-six (36) months from the date of the original qualifying event; or (2) within the eighteen (18) months *before* your original COBRA qualifying event, your eligible Dependents may continue coverage for up to thirty-six (36) months from the date you became entitled to Medicare.

You or your Dependents must notify the Plan of any second qualifying event within sixty (60) days after it occurs. Your failure to timely inform the Trust Fund Administrator will result in your loss of the right to extend COBRA coverage.

### **How to Elect COBRA Continuation Coverage**

To preserve your rights under COBRA, you must meet certain notification, election and payment deadline requirements.

Under COBRA, you or your Dependents must inform the Trust Fund Office in writing within sixty (60) days of a divorce or loss of Dependent status. The Trust Fund Office will notify you of your loss of eligibility and your employer is obligated to notify the Trust Fund Office of other qualifying events. However, you are encouraged to inform the Trust Fund Office of any qualifying event to assure prompt handling of your COBRA rights.

You will be asked to choose between COBRA “**Core-Only**” or COBRA “**Core-Plus**” coverage. You and your Dependents must elect either:

- COBRA “**Core-Only**”: hospital-medical and prescription coverage only, or
- COBRA “**Core-Plus**”: hospital-medical, prescription, dental coverage, and vision care.

COBRA Core-Plus will cost more than COBRA Core-Only because more benefits are provided. Benefits are the same as for eligible employees and deductibles and co-payments will apply as if there has been no gap in your coverage. The COBRA rates are adjusted annually and may be obtained from the Trust Fund Office. Once you have elected Core-Only coverage you may not change to Core-Plus, and vice versa.

Although Life Insurance benefits are not continued under COBRA, when your Life Insurance benefits end you will have the option to convert to an individual policy, as described on page 43 of this booklet.

If you elect COBRA continuation coverage, you pay the full cost of coverage for you and your Dependents plus a 2% administration fee (102% of the cost of the coverage to the Fund). This amount is established annually by the Board of Trustees. The premium rates will not change for twelve (12) months following a rate change unless the Board of Trustees revises the Plan.

Once the Trust Fund Office is notified of a qualifying event, it will send you information concerning your continuation options, including the necessary COBRA election forms. You will have **sixty (60) days** from the later of the date of the qualifying event or the date the COBRA notice is sent from the Fund Office in which to make your election. If you do not make your election within this **sixty (60) day** period, you will forfeit all rights to COBRA continuation coverage.

You have a maximum of **forty-five (45) days** from the date you mail your election form to the Fund Office in which to submit your first payment. This first payment must retroactively cover any period of time after the date that coverage was terminated. The Plan is pre-paid. Therefore, all subsequent payments are due on the 15th day of the month prior to the coverage month.

### **Important Eligibility Issues to Note for COBRA Coverage for Dependents**

To elect COBRA coverage, you must be covered under the Plan on the day before the qualifying event. Children born, adopted or placed with you for adoption during COBRA continuation coverage can be added to your COBRA coverage, as can a new spouse if you marry during your COBRA coverage period, however, such new Dependents do not experience a qualifying event if any of the above events occur during your COBRA coverage.

Under federal law your Domestic Partner and his or her eligible Dependents are *not* eligible for COBRA continuation coverage. Domestic Partners may, however, be eligible for Cal-COBRA continuation coverage, if enrolled in the Kaiser HMO. Check your HMO *Explanation of Coverage* for more information.

### **COBRA Notification Requirements**

You and your Dependent are responsible for informing the Trust Fund of a qualifying event such as divorce, legal separation, reaching an age limit, or loss of full-time student status. **A divorce or the termination of a Domestic Partnership is a COBRA qualifying event for your ex-spouse or ex-Domestic Partner. You must inform the Trust Fund Administrator within sixty (60) days of the qualifying event or sixty (60) days from the date your coverage ends, whichever is later.**

Your notification must be made in writing on a form that may be obtained, for no cost, by calling the Trust Fund Office at (415) 626-2000. Notice can be provided by anyone acting on your or your Dependent's behalf. If you fail to provide notice within this time period, you will not be able to elect COBRA continuation coverage. You must send notice of a qualifying event to the Health Plan at the address listed on page 58.

The notice must contain, at a minimum, the name of the Participant and any spouse or Dependents seeking COBRA coverage, a description of the qualifying event, and the date on which the qualifying event occurred. If the notice is incomplete, you may be asked by the Trust Fund Administrator to provide additional information.

If your Plan coverage ends because of your death, termination of employment or because of reduced work hours and the Trust Fund receives timely notice of these events, you and your Dependents will receive information from the Trust Fund Administrator regarding your COBRA coverage rights within thirty (30) days of any of these events. You and/or your Dependents will then have **sixty (60) days** to elect COBRA coverage.

### **Notice of Unavailability of COBRA**

If you or your Dependent provide the Trust Fund Administrator with a notice of a qualifying event, second qualifying event, or a determination of disability by the Social Security Administration, and the Trust Fund Administrator determines that you or your Dependent is not entitled to COBRA coverage or extended COBRA coverage, the Trust Fund Administrator will send you or your Dependent a notice that explains the reasons why you are not entitled to COBRA coverage. This notice will be sent to you within **fourteen (14) days** of receiving the initial notice of a qualifying event.

### **When COBRA Coverage Begins**

If you choose COBRA coverage at any time during your 60-day election period, coverage will be retroactive to the date of the qualifying event. However, your COBRA coverage will not begin until you timely submit your COBRA payments retroactive to your qualifying event.

### **COBRA Payment Shortfalls**

If you or your Dependent remits a timely monthly contribution to the Trust Fund but the payment is significantly less than the amount due, your COBRA coverage will be terminated immediately. The Trust Fund considers any COBRA payment to be significantly less if it is short by \$50 or 10% of the monthly COBRA payment, whichever amount is less.

For payments that are not significantly less than the amount due, but are still short of the actual monthly COBRA payment, the Trust Fund will notify you or your Dependent of the amount of the deficiency and permit you or your Dependent to pay the balance within thirty (30) days of the date of the notice of deficiency. You or your Dependent are responsible for paying all deficiencies. If you do not receive such a notice from the Trust Fund Office for payments not significantly less than the amount owed, your payment will be deemed to be sufficient payment for that month only and should not be understood to indicate that you can reduce your COBRA premium in future months.

### **If You Decide *Not* to Elect COBRA**

In deciding whether or not to elect COBRA continuation coverage, you should remember that if your group health coverage is not continued it might affect your rights under the federal law as follows:

- If you have more than a 63-day period without any health coverage your next group health plan can impose pre-existing condition exclusions.
- Your rights to purchase individual health insurance policies that do not impose pre-existing condition exclusions may be limited if you forgo continuation coverage in your group plan for the maximum time available to you.

You should also remember that you have the right to request special enrollment in another group health plan which might be available to you (such as through your spouse's employer) within thirty (30) days after termination of your group health coverage if the loss of coverage is due to the qualifying events listed above. You will also have this same special enrollment right if you elect COBRA and continue coverage to the end of the period allowed.

### **Waiver of COBRA**

If you waive your right to continue coverage under COBRA and if within the 60-day election period you decide that you would like to continue coverage, you may revoke that waiver as long as you send in the election form within that 60-day period. However, your coverage will only be reinstated as of the date of your election and you will not have coverage for any claims that you may have incurred between the date of your loss of coverage due to a qualifying event and the date that you revoked your waiver and elected COBRA.

### **Special COBRA Rights for Trade Displaced Employees**

If you lost coverage under the Plan because your employer shifted production to another country or because of detrimental competition from foreign imports, you may be eligible for a tax credit for your COBRA payments, provided you qualify for trade adjustment assistance or alternative trade adjustment assistance from the federal government and your state government. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance. Under the new tax provisions, eligible individuals can take a tax credit on their tax returns of 65% of premiums paid for qualified health insurance, including COBRA coverage. Advance payments of the tax credit may also be available.

If you have already lost medical coverage under the Plan, but within six (6) months become eligible to receive trade adjustment assistance, you may also be entitled to a second COBRA election period. To qualify, you must provide a copy of the certificate issued to you by your state workforce agency entitling you to federal trade adjustment assistance to the Trust Fund Administrator, which will provide you with a COBRA election notice. Your election to continue coverage must be made within sixty (60) days from when you first become eligible for trade adjustment assistance, but no later than six months after you lost Fund medical plan coverage. If you elect COBRA during this period, COBRA will begin on the first (1<sup>st</sup>) day of the second (2<sup>nd</sup>) election period. Your COBRA period, however, will be measured from the date you lost coverage under the Plan. In other words, the second election period will not extend the length of COBRA coverage.

If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at (866) 628-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

### **When COBRA Coverage Ends**

You and/or your Dependent's COBRA coverage terminates as of the earliest of the following dates:

- The end of the 18-month, 29-month or 36-month COBRA coverage period (whichever is applicable),
- The thirtieth (30th) day an outstanding COBRA payment is delinquent or short,
- The date your employer terminates its participation in the Plan and its Active Employees are enrolled in another group health plan (e.g. if this Plan is replaced with another plan),
- The date you or your Dependent becomes covered by another group health plan, unless that plan limits or excludes coverage of your or your Dependent's pre-existing condition, in which case the date the pre-existing condition is covered by the other plan or the end of the 18-month, 29-month- or 36-month COBRA period, whichever occurs first,
- The date a person on COBRA coverage becomes entitled to Medicare Part A, Part B or both,
- The month that begins thirty (30) days after a disabled person on extended COBRA coverage is no longer disabled,
- The date the Plan terminates (however, if the Plan is replaced, coverage may continue under the new plan), or

- The date coverage is terminated for cause on the same basis as for a similarly situated non-COBRA beneficiary, e.g., for filing a fraudulent claim or making a misrepresentation to the Fund. (The Trustees reserve the right to rescind coverage to the effective date of coverage).

### **Notice of Early Termination of COBRA**

If the Plan terminates COBRA coverage prior to the end of your or your Dependent's 18-month, 29-month or 36-month coverage period, the Trust Fund Administrator will provide you or your Dependent with a notice as soon as practicable following the Trust Fund Administrator's determination to terminate COBRA coverage. The notice will explain the reason for the early termination, the effective date of the termination, and the availability of alternative group or individual coverage, if any.

### **Keep the Plan Informed of Changes in Address**

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

### **Continuation of Coverage After COBRA**

At the end of the 18-month, 29-month, or 36-month COBRA period, you may be entitled to enroll in an individual conversion plan with Health Net or Kaiser. This plan may cost more and provide fewer benefits than your group health coverage and you will generally have only thirty (30) days to apply for this coverage after you lose group coverage. Contact Health Net or Kaiser at the address listed on page 62 if you are interested in this option.

### **"California COBRA"**

California law requires HMOs in the state to offer qualified beneficiaries who exhaust their 18-months or 29-months of federal COBRA coverage an additional period of continuation coverage, to a total of thirty-six (36) months from the date federal COBRA began. Cal-COBRA coverage may be subject to a higher monthly cost than federal COBRA coverage. Your eligibility for Cal-COBRA is based on your enrollment in a Health Net or Kaiser Program, not the U.A. Local 38 Health & Welfare Trust Fund – See your Health Net or Kaiser *Explanation of Coverage* for a description of your Cal-COBRA rights.

### **FAMILY AND MEDICAL LEAVE ACT**

The federal Family Medical Leave Act ("FMLA") and the California Family Rights Act ("CFRA") provide that in certain situations employers of fifty (50) employees or more are required to grant leave of **up to three (3) months** to employees to take care of family needs such as the birth and/or care of a newborn or newly adopted child, care of an ill child or spouse, to address the needs of the household if one parent is called to active duty service in the military, or to care for your own serious health condition. You and your eligible Dependents will continue to be covered under this plan provided they are eligible when the leave began and provided the employer makes the required contributions during the leave. It is not the role of the Trust Fund to determine whether or not a participant is entitled to Family and Medical Leave Act leave with medical coverage. Any questions regarding entitlement to FMLA or CFRA leave must be resolved by the employer and U.A. Local 38.

To the extent that you are entitled to leave with continuing medical coverage, the Plan will provide continued coverage for up to three (3) months provided that the employer contributions required for coverage are timely made to the Trust Fund. Rights under this section of the Plan are independent of your rights to COBRA continuation coverage in the event of disability. However, a COBRA “qualifying event” may occur if you do not return to work upon expiration of your FMLA or CFRA leave, or if you give your employer notice that you do not intend to return to work after your leave.

#### **LEAVE FOR MILITARY SERVICE**

The Uniformed Services Employment and Re-Employment Rights Act (“USERRA”) provides that your employer-paid coverage continues if you leave your job for active duty or training in the U.S. Armed Forces for a period of thirty-one (31) days or less. If the leave extends beyond thirty-one (31) days, you are entitled to self-pay for coverage for up to twenty-four (24) months from the date your leave started, or the date your leave ends if your leave ends and you do not reapply for employment with your employer, whichever comes first. If you elect to continue coverage under USERRA, the amount charged will be determined by the Board of Trustees from time to time and shall not be more than 102% of the full premium under the Plan (determined in the same manner as the applicable premium under COBRA). The procedure for electing USERRA self-pay coverage is the same as the procedure for electing COBRA described above.

#### **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) may affect your health coverage if you are enrolled or become eligible to enroll in a health plan that excludes coverage for pre-existing medical conditions. The U.A. Local 38 Health & Welfare Plan does not exclude coverage for pre-existing medical conditions. However, the information contained in this section is important if your coverage ends and you become eligible for coverage in another plan.

HIPAA limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than twelve (12) months (eighteen (18) months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion.

Please note that your prior health coverage may not be used to reduce any pre-existing condition limitation if there has been a break in coverage of 63 days or more between your loss of coverage under this Plan and the beginning of coverage under your new plan.

#### **CERTIFICATE OF COVERAGE**

When you or your Dependent lose medical, dental and/or vision coverage under the Plan, the Trust Fund will send to your last known address a “Certificate of Coverage” that states how long you were continuously covered under the Plan. You will receive this Certificate even if you

elect to continue your coverage through COBRA (as described on page 9). A Certificate of Coverage will also be issued upon request.

You may need this Certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that existed prior to your enrollment in the new group plan (for more information on this, see “Health Insurance Portability and Accountability Act” above).

If you have any questions or need a Certificate of Coverage, contact the Trust Fund Office.

# MEDICAL BENEFITS

## YOU HAVE A CHOICE BETWEEN THREE DIFFERENT MEDICAL OPTIONS:

- Option #1 – HEALTH NET PREFERRED PROVIDER (“PPO”) NETWORK
- Option #2 – HEALTH NET HMO
- Option #3 – KAISER HMO

The following table compares benefits under the three options and is intended only as a summary of the main differences in coverage between the three (3) medical options available under the Plan. FOR ADDITIONAL INFORMATION ABOUT EACH OPTION, INCLUDING LIMITATIONS AND EXCLUSIONS, REFER TO THE *EVIDENCE OF COVERAGE* BOOKLET (CALLED AN “EOC”) PROVIDED BY HEALTH NET AND KAISER. Once you have chosen your medical option you will be provided with the appropriate EOC. However, you can obtain a copy of the Health Net or Kaiser EOCs by calling the Trust Fund Office.

## ENROLLMENT AND OPEN ENROLLMENT

When you first become eligible for benefits you will be asked to choose one of the Plan’s three medical options. The choice you make for yourself is the choice that will also apply to your spouse and Dependents. You can change your medical option only during the annual open enrollment – which is generally held during the months of May and **June** for a **July 1** effective date (in other words, if you elect to change your medical option during open enrolment the change will be effective July 1, even if you have not yet received new medical option ID cards).

## YOUR MEDICAL OPTIONS: HEALTH NET PPO, HEALTH NET HMO & KAISER HMO

The dollar or percentage amounts shown in the Chart’s boxes show how much you pay for the benefit described.

Benefits	Health Net PPO		Health Net HMO	Kaiser Permanente HMO
	In-Network <sup>1</sup>	Out-of-Network <sup>2</sup>	HMO Network Only	HMO Network Only
Annual Deductible	None	\$100/Ind. \$300/Family	None	None
Annual Out-of-Pocket Maximum	\$1,000 combined per calendar year <sup>3</sup>		\$1,500/Ind. \$4,500/Family	\$1,500/Ind. \$3,000/Family
Lifetime Maximum	\$2,000,000 lifetime max. per covered person <sup>3</sup>		None	None
<b>PROFESSIONAL SERVICES</b>				
Physician Office Visit	\$20	20%	\$10	\$10
Routine Physical Exam	\$20 (\$250 max. per cal. year) <sup>3</sup>		\$10	\$10
Specialist Office Visit	\$20	20%	\$10 <sup>16</sup>	\$10

Benefits	Health Net PPO		Health Net HMO	Kaiser Permanente HMO
Eye Exams	\$20 (birth through age 16 ONLY)	20% (birth through age 16 ONLY)	\$10	\$10
Hearing Exams	\$20 (birth through age 16 ONLY)	20% (birth through age 16 ONLY)	\$10	\$10
Allergy Testing	\$20	20%	Covered in full	\$10
Allergy Serum & Injection	\$20	20%	Covered in full	\$3
Laboratory & X-Ray	Covered in full <sup>6</sup>	20% <sup>6</sup>	Covered in full	Covered in full
Rehabilitative Therapy (physical, speech, occupational, cardiac, and pulmonary)	\$20 <sup>7</sup>	20% <sup>7</sup>	\$10	\$10
<b>PREVENTATIVE – PROFESSIONAL SERVICES</b>				
Adult Preventative-Periodic Health Evaluations, including well-woman exams and immunizations (age 17 and older)	\$20 (age 17 and older) <sup>8</sup>	20% (age 17 and older) <sup>8</sup>	\$10 (age 18 and older) <sup>16, 18</sup>	\$10
Child Preventative-Periodic Health Evaluations, including newborn, well-child, and immunizations (birth through age 17)	\$20 (birth through age 16) <sup>9</sup>	20% (birth through age 16) <sup>9</sup>	\$10 (birth through age 17) <sup>16, 18</sup>	\$5 (birth through 23 months)
<b>FAMILY PLANNING – PROFESSIONAL SERVICES<sup>10, 19</sup></b>				
Family Planning Office Visits	\$20	20%	\$10	\$10
Elective Abortions	Covered in full	20%	\$150	\$10
Injectable Contraceptives (including but not limited to Depo Provera)	\$20	20%	Covered in full	\$10
Infertility Services and Supplies	Covered in full (\$2,000 lifetime max.) <sup>3, 13</sup>	20% (\$2,000 lifetime max.) <sup>3, 13</sup>	50%	\$10
Vasectomy	Covered in full	20%	\$50	\$10
Tubal Ligation	Covered in full	20%	\$100	\$100

Benefits	Health Net PPO		Health Net HMO	Kaiser Permanente HMO
<b>MATERNITY CARE</b>				
Prenatal and Postnatal Office Visits	Covered in full	20%	\$10	\$5
Normal Delivery, Cesarean Section, Newborn Inpatient Care	Covered in full <sup>6</sup>	20% <sup>6</sup>	Covered in full	Covered in full
Genetic Testing of Fetus	Covered in full	20%	Covered in full	Covered in full
Circumcision of Newborn Males (birth through 30 days)	Covered in full	20%	Covered in full	Covered in full
Inpatient Hospital Facility Charge	\$100	20%	\$100	\$100
<b>HOSPITAL SERVICES</b>				
Inpatient Hospital Stay (semi-private room or intensive care unit with ancillary services for unlimited days)	\$100 <sup>6</sup>	\$100 + 20% <sup>6</sup>	\$100	\$100
Skilled Nursing Facility Stay	\$100 (180 days max. per cal. year) <sup>3, 6</sup>	\$100 + 20% (180 days max. per cal. year) <sup>3, 6</sup>	\$100 (100 days max. per cal. year)	\$100 (100 days max. per cal. year)
Outpatient Facility Services (other than surgery)	Covered in full <sup>6</sup>	20% (Health Net daily max. is 50% of billed charges) <sup>6</sup>	Covered in full	\$10
Outpatient Surgery (surgery performed in a hospital or outpatient surgery center)	Covered in full <sup>5, 6</sup>	20% (Health Net daily max. is 50% of billed charges) <sup>5, 6</sup>	Covered in full <sup>17, 21</sup>	\$10
Hospitalization for Infertility Services	\$100 (subject to the \$2,000 lifetime max.) <sup>6, 13</sup>	20% (subject to the \$2,000 lifetime max.) <sup>6, 13</sup>	50%	\$100
<b>EMERGENCY HEALTH COVERAGE</b>				
Emergency Room	\$50 <sup>11</sup>	\$50+20% <sup>11</sup>	\$50 <sup>20</sup>	\$50
Urgent Care	\$10 <sup>11</sup>	\$10+20% <sup>11</sup>	\$50 <sup>11</sup>	\$50
Group Ambulance	20%	20%	Covered in full	Covered in full
Air Ambulance	20% <sup>6</sup>	20% <sup>6</sup>	Covered in full	Covered in full

Benefits	Health Net PPO		Health Net HMO	Kaiser Permanente HMO
OTHER SERVICES (You pay the amount shown in the box)				
Acupuncture Services	\$20 (12 max. visits per cal. year) <sup>3</sup>	20% (12 max. visits per cal. year) <sup>3</sup>	Not Covered	Not Covered
Chiropractic Services	\$20 (20 max. visits per cal. year) <sup>3</sup>	20% (20 max. visits per cal. year) <sup>3</sup>	\$5 (40 max. visits per cal. year) <sup>23</sup>	\$5 (40 max. visits per cal. year) <sup>23</sup>
Annual Chiropractic Appliance Allowance	\$50 <sup>3</sup>		\$50	Not Covered
Medical Social Services	Covered in full	20%	Covered in full	Covered in full
Patient Education	Covered in full	20%	Covered in full	\$10
Durable Medical Equipment	Covered in full <sup>6</sup>	20% <sup>6</sup>	Covered in full	Covered in full
Orthotics (such as bracing, supports and casts)	Covered in full <sup>6</sup>	20% <sup>6</sup>	Covered in full	Covered in full
Diabetic Equipment	Covered in full <sup>12</sup>	20% <sup>12</sup>	Covered in full <sup>22</sup>	Covered in full
Diabetic Footwear	Covered in full <sup>12</sup>	20% <sup>12</sup>	Covered in full <sup>22</sup>	Covered in full
Prostheses	Covered in full <sup>6</sup>	20% <sup>6</sup>	Covered in full <sup>22</sup>	Covered in full
Blood, Blood Plasma, Blood Derivatives, and Blood Factors	Covered in full	20%	Covered in full	Covered in full
Nuclear Medicine	Covered in full	20%	Covered in full	Covered in full
Organ and Bone Marrow Transplants (non-experimental and non-investigative)	Covered in full <sup>6</sup>	20% <sup>6</sup>	Covered in full	Covered in full
Chemotherapy	Covered in full	20%	Covered in full	Covered in full
Renal Dialysis	Covered in full	20%	Covered in full	\$100/Inpatient \$10/Outpatient (1 visit per month)
Home Health Services	Covered in full	20%	\$10	Covered in full (up to 100-hour visits per cal. year)
Hospice Services	Covered in full <sup>6</sup>	20% <sup>6</sup>	Covered in full	Covered in full

Benefits	Health Net PPO		Health Net HMO	Kaiser Permanente HMO
Infusion Therapy (home or physician's office)	Covered in full (home or doctor's office with 14 day supply max. per each delivery) <sup>6</sup>	20% (home or doctor's office with 14 day supply max. per each delivery with \$500 Health Net Life daily max.) <sup>6</sup>	Not Covered	Covered in full (home or doctor's office for up to a 30-day supply only)
<b>MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES</b>				
Non-Severe Mental Disorder/Chemical Dependency-Outpatient Office Visits	\$20 (30 max. visits per cal. year) <sup>3</sup>	20% (30 max. visits per cal. year) <sup>3</sup>	\$30 (20 max. visits per cal. year) <sup>15</sup>	\$10 (20 max. visits per cal. year)
Non-Severe Mental Disorder/Chemical Dependency-Outpatient Group Visits	Not Covered	Not Covered	\$15 (20 max. visits per cal. year) <sup>15</sup>	\$5 (20 max. visits per cal. year)
Non-Severe Mental Disorder/Chemical Dependency-Inpatient Hospitalization	\$100 (30 days maximum per calendar year with 60-day & \$25,000 lifetime max. for chemical dependency only) <sup>3, 6</sup>	20% 100 (30 days maximum per calendar year with 60-day & \$25,000 lifetime max. for chemical dependency only) <sup>3, 6</sup>	\$100 (30 maximum days per calendar year) <sup>15</sup>	\$100 (up to 45 days maximum for mental health & up to 30 days maximum for chemical dependency)
Acute Care Detoxification	\$100 (3 days maximum per calendar year) <sup>3, 6</sup>	20% (3 days maximum per calendar year) <sup>3, 6</sup>	\$100 (3 days maximum per admission) <sup>15</sup>	\$100
<b>SEVERE MENTAL HEALTH SERVICES</b>				
Outpatient Office Visits	\$20 <sup>4</sup>	20% <sup>4</sup>	\$10 <sup>15</sup>	\$10
<i>Inpatient Hospitalization</i>	\$100 <sup>6</sup>	20% <sup>6</sup>	\$100 <sup>15</sup>	\$100

This *Benefit Matrix* is only a summary of your health plan. Your *Evidence of Coverage*, which you will receive after you enroll, contains the exact terms and conditions of your chosen coverage. It is important for you to carefully read your *Evidence of Coverage* thoroughly once received, especially those sections that apply to those with special health care needs.

### **Footnotes Contained In The Benefits Matrix**

The numbers in the above table refer to the following:

1. For the PPO level of benefits, the percentages that appear in this chart are based on allowable charges and contracted rates with providers.
2. For Out-of-Network level of benefits, the percentages that appear in this chart are based on the Usual & Customary Rates (“UCR”). The covered person is responsible for charges in excess of UCR fees in addition to the coinsurance shown.
3. Combined for PPO and Out-of-Network.
4. Severe mental illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rhetts’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*), autism, anorexia nervosa and bulimia nervosa.

Serious emotional disturbances of a child is when a child under the age of eighteen (18) has one or more mental disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary chemical dependency disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms. In addition, the child must meet one of the following: (a) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

5. Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymph edema.
6. These services require pre-certification for coverage. For a complete listing of services requiring pre-certification please refer to the “Services Requiring Certification” section of this Summary Benefits/Disclosure Form. Routine care for pregnancy does not require prior certification. However, notification of pregnancy is requested. If pre-certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a \$500 penalty will be charged for inpatient admissions and a \$50 penalty for outpatient visits.

7. Additional visits are payable if pre-certified as medically necessary following neurological and orthopedic surgery, cerebral cardiovascular accident, third degree burns, head trauma, or spinal cord injuries.
8. Provided on the basis of age, medical need and health status. Adult preventive care includes: mammography, cervical cancer screening test/pelvic and breast exams, and sigmoidoscopy (refer to the *Certificate* for frequency and guidelines).
9. Limited to evaluation and management of child's physical development for prevention of future medical problems, laboratory tests, x-rays and standard immunizations.
10. The coinsurance amounts apply to professional services only. Services that are rendered in a hospital are also subject to the hospital services coinsurance. See "Hospital Services" in this section to determine if any additional co-payments or coinsurance may apply.
11. The coinsurance shown for PPO emergency health care services will be applied for all emergency care, regardless of whether or not the health care provider is a PPO or non-contracting provider. The coinsurance shown for PPO and Out-of-Network providers are applicable only if non-emergency care is provided at an emergency room or urgent care center.
12. Diabetic equipment and supplies are covered under the medical benefit (through "Diabetic Equipment") and include blood glucose monitors (and monitors designed for the visually impaired) and testing strips, corrective footwear, insulin pumps and related supplies, specific brands of pen delivery systems for the administration of insulin (including pen needles), Ketone test strips, insulin syringes, and lancets and puncture devices when used in monitoring blood glucose levels. Your physician must contact the Health Net Pharmacy Department for prior authorization before you can obtain the following covered items upon presentation of your prescription at a contracting Health Net Pharmacy: reusable pen delivery systems, specific brands of disposable insulin needles and syringes, and disposable pen needles.
13. All services and supplies relating to infertility treatment are subject to \$2,000 lifetime benefit maximum.
14. The percentages that appear in this chart are based on amounts agreed to in advance by Health Net and the member's physician group or other authorized health care provider.
15. Please refer to the "Behavioral Health Services" section of this Summary Benefits/Disclosure Form for the definitions of severe mental illness and serious emotional disturbances of a child. Benefits are administered through Managed Health Network ("MHN").

\*Applicable only for outpatient counseling defined as individual office visits and group therapy sessions. Group sessions are equal to half of an individual session and count towards the visit maximum. In addition, outpatient mental health and chemical dependency are limited to a combined maximum number of visits each calendar year.

\*\*Inpatient admission means any admission to a hospital, day treatment program, residential treatment center or structured outpatient program. The co-payment is applicable for each

admission. In addition, inpatient mental health and chemical dependency (excluding detoxification) are limited to a combined maximum number of days each calendar year.

\*\*\*The mental disorder co-payments and day or visit limits will not apply for severe mental illness or serious emotional disturbances of a child as defined. Services for these conditions require whatever co-payment would be required if the services were provided for a medical condition. Refer to the “Schedule of Benefits and Coverage” section of this Summary Benefits/Disclosure Form to determine the applicable co-payment. All other mental disorders will be subject to the co-payments shown under the heading “Non-Severe Mental Disorder Benefits/Health Net HMO.”

16. Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Co-payment requirements may differ depending on the services provided.
17. Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymph edema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your Primary Care Physician.
18. For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papilloma virus (“HPV”) screening test that is approved by the federal Food and Drug Administration (“FDA”), and the option of any cervical cancer screening test approved by the FDA.
19. These co-payments apply to professional services only. Services that are rendered in a hospital are also subject to the hospital services co-payment. See “Hospital Services” in this section to determine if any additional co-payments may apply.
20. Co-payments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member’s physician group will be considered an office visit and the office visit co-payment, if any, will apply.
21. Diagnostic endoscopic procedures, such as diagnostic colonoscopy, performed in an outpatient facility require the co-payment applicable for outpatient facility services. If, during the course of a diagnostic endoscopic procedure performed in a hospital or outpatient surgical center, a therapeutic (surgical) procedure is performed, then the co-payment applicable for outpatient surgery will be required instead of the co-payment for outpatient facility services.
22. Diabetic equipment and supplies are covered under the medical benefit (through “Diabetic Equipment”) and include blood glucose monitors (and monitors designed for the visually impaired) and testing strips, insulin pumps and related supplies, corrective footwear, specific brands of pen delivery systems for the administration of insulin (including pen needles), Ketone test strips, specific brands of insulin syringes, and lancets and puncture devices when

used in monitoring blood glucose levels. In addition, the following supplies are covered under the medical benefit as specified; visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prostheses benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit). Your physician must contact the Health Net Pharmacy Department for prior authorization before you can obtain the following covered items upon presentation of your prescription at a contracting Health Net Pharmacy: specific brands of pen delivery systems, disposable insulin needles and syringes (specific brands only), and disposable pen needles.

23. Co-payments for the following services and supplies do not apply to the out-of-pocket maximum: Chiropractic care.

## THE HEALTH NET PPO NETWORK

To enroll in the Health Net PPO Program you must live or work in one of the counties in which Health Net offers its PPO Network. For a list of counties in Health Net's network call (800) 522-0088 or go to Health Net's website [www.healthnet.com](http://www.healthnet.com).

The Health Net's Preferred Provider Organization (PPO) Program covers:

- claims incurred with hospitals and doctors in the Health Net Preferred Provider Network, *and*
- claims incurred with hospitals and doctors *outside* the Health Net Preferred Provider Network and for which Health Net will pay 80% of "usual and customary" charges after you have satisfied the annual deductibles (called "the Non-Preferred Option").

This means you can choose your own doctors for all your health care needs but the amount of your claim that will be paid will depend on whether you use a Health Net PPO-Network doctor or hospital.

For some services, pre-certification of treatment is necessary to obtain the full benefit (see "Services Requiring Prior Authorization" in the Health Net *Explanation of Coverage* for details). Each time you or a covered family member needs care, you have the following choices:

- "In-PPO-Network," means a doctor or hospital on the Health Net PPO Provider Listing.
- "Out-of-PPO-Network," means a doctor or hospital **not contracted** with Health Net PPO.

Doctors come in and out of the Health Net PPO Network all the time. If you have used a doctor once when he/she was in the PPO and use him again later, he/she may not still be in the PPO Network. **It is your responsibility to verify whether any doctor or hospital you use is currently enrolled in the Health Net PPO Provider Network. If you fail to check your doctor's status before he/she treats you, you may find that he/she is not in the Network and your claim will be paid at 80%, leaving you with an out-of-pocket expense (after you have satisfied the deductible) of 20%.**

### **How to Find Out Whether Your Doctor or Hospital is in the Network**

- Call Health Net at (800) 522-0088
- Check Health Net's website: [www.healthnet.com](http://www.healthnet.com)

FOR ADDITIONAL INFORMATION ABOUT THE HEALTH NET PPO OPTION, INCLUDING LIMITATIONS AND EXCLUSIONS, REFER TO YOUR *EVIDENCE OF COVERAGE* BOOKLET (CALLED AN "EOC") PROVIDED BY HEALTH NET.

## **THE HEALTH NET HMO**

### **Eligibility for the Health Net HMO**

To enroll in the Health Net HMO Program you must live or work in one of the counties in which Health Net offers its HMO. For a list of counties in the Health Net Network call (800) 522-0088 or go to Health Net's website [www.healthnet.com](http://www.healthnet.com).

### **Choosing a Physician**

As a Member of the Health Net HMO, you need to select a Primary Care Physician. The physician you select will provide or coordinate the provision of your medical and hospital services.

Here's how to select your Primary Care Physician:

- From your Health Net HMO Provider Directory, choose a Primary Care Physician ("PCP") or Participating Medical Group ("PMG") within thirty (30) miles of your home or workplace. The HMO Provider Directory is also available on-line at [www.healthnet.com](http://www.healthnet.com).
- If you choose a Participating Medical Group and would like help selecting a Primary Care Physician who is a member of that Group, you can contact the Group's Health Plan Coordinator by calling the listed telephone number.
- When selecting your Primary Care Physician, please keep in mind:
  - The Primary Care Physician you and your employed Dependents choose must be located within a thirty (30) mile radius of either your Primary Residence or Workplace. All other Dependents must select a physician within a thirty (30) mile radius of your Primary Residence, Daycare, or School.
  - Each family member may choose a different Primary Care Physician.

If you do not select a Physician at enrollment (*and list the physician you have selected on your enrollment application*), Health Net will assign a physician for you and each of your Dependents.

### **Accessing Care**

#### **Scheduling Appointments**

After you have selected a Primary Care Physician, make your appointments by phone:

- For routine office visits, Health Net recommends calling at least 48 hours in advance.
- For health evaluation appointments, such as your yearly physical, Health Net suggests calling at least two (2) weeks in advance.
- If you need more immediate attention, call your Primary Care Physician and request the next available appointment.

#### **Referrals to Specialists**

The Primary Care Physician you have selected will coordinate all of your health care needs.

- If your Primary Care Physician determines you need to see a specialist, he or she will make an appropriate specialist referral.

- Your Primary Care Physician will determine the number of specialist's visits that you require and will provide you with any other special instructions.

#### Standing Referrals to Specialists

You may receive a standing referral to a specialist if your Primary Care Physician determines in consultation with the specialist and your Participating Medical Group's Medical Director or a Health Net Medical Director, that you need continuing care from a specialist. A "standing referral" means a referral by your Primary Care Physician for more than one visit to a participating specialist as indicated in the treatment plan, if any.

#### Extended Referral for Coordination of Care by Specialist

If you have a life-threatening, degenerative, or disabling condition or disease that requires specialized medical care over a prolonged period of time, you may receive a referral to a participating specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate your health care.

#### Direct Access to Obstetrical/Gynecological Physician Services

You may obtain obstetrical and gynecological ("OB/GYN") physician services directly from a participating OB/GYN or Participating Family Practice Physician (designated by your Participating Medical Group/Individual Practice Association as providing OB/GYN physician services) affiliated with your Participating Medical Group.

You must still notify Health Net or your Primary Care Physician/Participating Medical Group within 24 hours or as soon as reasonably possible after the onset of the need for emergency care.

FOR ADDITIONAL INFORMATION ABOUT THE HEALTH NET HMO OPTION, INCLUDING LIMITATIONS AND EXCLUSIONS, REFER TO YOUR *EVIDENCE OF COVERAGE* BOOKLET (CALLED AN "EOC") PROVIDED BY HEALTH NET.

## **THE KAISER HMO**

### **Eligibility for the Kaiser HMO**

To enroll in the Kaiser HMO Program you must live or work in one of the counties in which Kaiser offers its HMO. For a list of counties in the Kaiser Network call (800) 464-4000 or go to Kaiser's website [www.kaiserpermanente.org](http://www.kaiserpermanente.org).

### **How the Kaiser HMO Works**

Except in the event of an emergency you are required to obtain all your medical care from Kaiser at Kaiser facilities.

### **Choosing a Physician**

As a Member of the Kaiser HMO, you need to select a Primary Care Physician from the available Kaiser Plan physicians. The physician you select will provide or coordinate the provision of your medical and hospital services and referral to specialists.

FOR ADDITIONAL INFORMATION ABOUT THE KAISER HMO OPTION, INCLUDING LIMITATIONS AND EXCLUSIONS, REFER TO YOUR *EVIDENCE OF COVERAGE* BOOKLET (CALLED AN "EOC") PROVIDED BY KAISER.

If you have any questions or require additional information, please call a Member Service Representative at (800) 464-4000.

# PRESCRIPTION DRUG COVERAGE

Whether you are enrolled in the Health Net or Kaiser medical options, your prescription drug coverage is provided through **Envision Rx Options, Inc.** Prescription drugs are covered provided that you fill your prescriptions at an Envision Rx Options pharmacy or through the Envision Rx Options mail order program with Costco. **Prescriptions purchased at a non-network pharmacy are not covered.**

## WHAT PRESCRIPTIONS ARE COVERED?

There is no “formulary” or list of covered medications: a drug will be covered if it has been approved by the U.S. Food and Drug Administration (“FDA”) for the medical condition prescribed and not otherwise excluded by the Plan. The drugs in the following list are examples of drugs typically covered by the Plan. If you have a question regarding whether a particular drug is covered call the Envision Rx Options help desk at (800) 361-4542.

Benefits are payable for the following types of prescriptions:

- **Pharmaceuticals requiring a written prescription and dispensed by a licensed pharmacist (or by a hospital pharmacy during a period not involving hospital confinement for the treatment of an illness or injury)**
- **Prenatal vitamins**
- **Insulin and diabetic supplies**
- **Contraceptives**
- **Injectables**

For a list of drugs that are **not covered** by the Plan, see the “Exclusions from Coverage” section below.

## HOW TO USE YOUR BENEFITS AT A RETAIL PHARMACY

- **Go to a Participating Pharmacy**

For a listing of Envision Rx Options pharmacies go to [www.envisionrx.com](http://www.envisionrx.com) or contact the Trust Fund Office at (415) 626-2000.

- **Present your Envision Rx Options Card and your prescription to the Pharmacist**
- **Pay the required co-payment listed below:**

### ACTIVES AND THEIR DEPENDENTS:

Brand Name Prescription	\$10.00 (30 day supply)
Generic Prescription	NO CO-PAY (30 day supply)

### RETIREES AND THEIR DEPENDENTS:

Brand Name Prescription	\$15.00 (30 day supply)*
Generic Prescription	\$5.00 (30 day supply)*

\*Retiree drug coverage is limited to an annual maximum benefit of **\$3,000 per person per fiscal year** (this annual maximum applies to all prescriptions, whether filled by a retail or mail order pharmacy).

## **DISPENSING LIMITATIONS**

The quantity of each medication dispensed at a retail pharmacy shall be limited to a 30 or less day supply.

## **THE MAIL SERVICE PROGRAM**

You may receive up to a ninety (90) day supply of maintenance medications by using the mail order program. Your co-payment under the mail order program is as follows

### **ACTIVES AND THEIR DEPENDENTS:**

Brand Name Prescription	\$10.00 (90 day supply)
Generic Prescription	NO CO-PAY (90 day supply)

### **RETIREEES AND THEIR DEPENDENTS:**

Brand Name Prescription	\$15.00 (90 day supply)*
Generic Prescription	\$5.00 (90 day supply)*

\*Retiree drug coverage is limited to an annual maximum benefit of **\$3,000 per person per fiscal year** (this annual maximum applies to all prescriptions, whether filled by a retail or mail order pharmacy).

## **How to Use the Mail Order Program**

- If you need to start on your maintenance medication right away, have your physician complete two prescriptions. Fill one immediately at a participating pharmacy and submit the other to your mail service program.
- Please remember that the prescription order must be legible and must indicate the drug's name, strength, the quantity to dispense, the exact daily dosage and the physician's name, phone number and his/her DEA number.
- Attach your original prescription to your mail service order form and fill out the area provided for each new prescription. Prescriptions(s) must be written on a physician's original signature. Fill out the Patient Health Profile (available through your Trust Fund office) if this is your first order with us, or anytime there is a significant change in your health.
- Mail your original prescription(s), the completed mail service order form, and your patient health profile in the return envelope provided.

## **How to Order Refills**

Remember to order your prescription refill **at least (3) three weeks** before your current supply runs out. Normally you can expect to receive your refill within fourteen (14) business days from the day we receive your order.

## REGIONAL CHAIN PHARMACIES IN THE ENVISION RX NETWORK

### Participating Pharmacy List

A list of participating pharmacies is available at no cost from Envision Rx. You can also call Envision Rx Options at (800) 361-4542 or go online ([www.envisionrx.com](http://www.envisionrx.com)) to find a participating pharmacy.

The following is a list of the major chain pharmacies currently in the Envision Rx retail pharmacy network:

Bel Air Pharmacies	Raley's Drugs
Big A Drugstores	Rite-Aid
Costco	Safeway
CVS	Save Mart
Horton & Converse Pharmacy	Sav-On Drugs
K Mart Pharmacy	Target
Longs Drugs Stores	Von's Drugs
Lucky's Pharmacy	Walgreens
Medicine Shoppe	

For other chains and independently owned pharmacies contact the Trust Fund Office at (415) 626-2000 or go to [www.envisionrx.com](http://www.envisionrx.com) for member site directory.

### UTILIZATION REVIEW

The Trust Fund and Envision Rx Options reserve the right to monitor the dosage and treatment patterns related to all prescriptions which exceed \$500. Such prescriptions require prior authorization.

### DRUGS THAT ARE *NOT* COVERED

No prescription drug benefits will be paid for the following:

1. Patent or proprietary medicines not requiring a prescription
2. Immunization agents, biological sera, blood or blood plasma, or medication prescribed for parenteral use or administration (except insulin)
3. Appliances and other non-drug items
4. Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, or health and beauty aids
5. Smoking cessation medication
6. Drugs for which reimbursement is provided or paid for by any other group plan or federal, state, county, or municipal government program
7. Any single filling or refilling of a prescription for drugs taken in accordance with the doctor's directions in excess of a 100-day period unless a prior written agreement has been reached with the Fund

8. Prescription charges due to occupational injuries or due to sickness covered by Workers' Compensation laws or similar legislation
9. Drugs not approved by the FDA
10. Prescription drug claims filed more than ninety (90) days after the prescription is filled
11. Any charges excluded by the Plan
12. Cosmetic, health or beauty aids
13. Fertility drugs

### **IT IS IMPORTANT TO BE AWARE OF DRUG INTERACTION**

If you are taking other medications, and especially if you are being treated by more than one (1) doctor at a time, make sure the prescribing physician is aware of these medications. Drug interaction, misuse and abuse have been found to be a major contributor to prolonged or to newly acquired illnesses.

### **MEDICARE PART D AND RETIREES**

The prescription drug coverage offered by the Trust Fund is comparable to prescription drug plans offered under Medicare "Part D" (Medicare prescription drug coverage). The federal Centers for Medicare and Medicaid Services ("CMS") will consider your coverage under this Plan to be "creditable," which means that, on average, the Plan will pay as much or more for your prescription drug coverage than Medicare would pay if you enrolled in Part D. ***You should not enroll in Medicare Part D coverage if you intend to continue your prescription drug coverage under the UA Local 38 Health Plan. However, the choice is yours: If you decide that another Medicare Part D drug plan is better for you than this Plan and enroll in a Part D drug plan, your eligibility for prescription drug coverage in this Plan will end.***

Medicare expects you to enroll in a Part D drug plan as soon as you become eligible, and charges higher premiums to late enrollees, *unless you are already covered by creditable prescription drug coverage* like your coverage under this Plan. Because your coverage under this Plan is deemed "creditable" by Medicare for purposes of Part D, if you decide to enroll in Part D in the future – because, for example, your Fund coverage terminates – you will not be penalized for late enrollment in Part D. If your Fund coverage ends, you will have 62 days to enroll in another Medicare Part D drug plan without incurring a late enrollment premium.

# DENTAL BENEFITS

## DELTA DENTAL

The Plan's Dental Benefits are administered through Delta Dental. While you can go to any dentist you want, the thousands of dentists enrolled in the Delta Dental program have agreed to accept Delta's fee schedule, so the amount of your claim that will be covered by the Plan is likely to be higher if you use a Delta dentist.

## CHOOSING A DENTIST

While you are not required to use a Delta dentist, the amount paid for your dental treatment is likely to be higher if you use a Delta dentist. To check whether your dentist is a Delta dentist or to choose a dentist, call Delta Dental at (800) 765-6003 or go to the Delta Dental website [www.deltadentalins.com](http://www.deltadentalins.com).

## WHAT IS COVERED?

The dental program covers the services of a licensed dentist providing treatment within accepted standards of dental practice to prevent, diagnose and treat conditions.

Benefits are limited to the applicable percentages of dentist's fees or allowances specified below. You are required to pay the balance of any such fee or allowance, known as the "patient co-payment." If the dentist discounts, waives or rebates any portion of the patient co-payment to you or your Dependent, Delta will reduce what it pays by the amount that such fees or allowances are discounted, waived or rebated.

## ANNUAL DEDUCTIBLE

Each year you must satisfy the \$50 individual deductible and \$150 (maximum) family deductible. However, the deductible does not apply to Diagnostic and Preventative Benefits.

### I. Diagnostic and Preventative Benefits – 80%

Diagnostic-oral examination, x-rays, diagnostic casts, biopsy/tissue examination, emergency treatment, consultation by a specialist.

Preventive-prophylaxis (cleaning), fluoride treatment, space maintainers.

### Limitations

- a) An oral examination by a Delta Dentist is a benefit only if the Dentist has an accepted fee on file with us for this procedure.
- b) Oral examinations are benefits twice in a calendar year.
- c) Prophylaxes (cleaning), fluoride treatment or procedures that include cleanings are benefits twice in a calendar year.
- d) Unless special need is shown, full mouth x-rays are benefits once in a five (5) year period.
- e) Bitewing x-rays are benefits twice in a calendar year for children up to age eighteen (18) or once in a calendar year for adults age eighteen (18) and over.

## **II. Basic Benefits – 80%**

Oral surgery-extractions and certain other surgical procedures, including pre-and post-operative care

Restorative-amalgam, synthetic, plastic or resin restorations (fillings) for treatment of cavities (decay)

Endodontic-treatment of the tooth pulp

Periodontic-treatment of gums and bones that support the teeth

Sealants-topically applied acrylic, plastic or composite material used to seal development grooves and pits in teeth for the purpose of preventing dental decay

Adjunctive General Services- general anesthesia, office visit for observation, office visit after regularly scheduled hours, therapeutic drug injection, treatment of post-surgical complications (unusual circumstances), and occlusal adjustment, limited

### **Limitations**

- a) Periodontal procedures that include cleanings are subject to the same limitations as other cleanings; i.e., cleanings of any kind are benefits no more than twice in any calendar year.
- b) Sealant benefits include the application of sealants only to permanent first molars through age eighteen (18) and second molars through age fifteen (15) without decay, without restorations and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.

## **III. Crowns, Jackets, Inlays, Onlays and Cast Restoration Benefits – 80%**

Crowns, jackets, inlays, onlays and cast restorations are benefits only if they are provided to treat cavities that cannot be directly restored with amalgam, synthetic, plastic or resin fillings.

### **Limitations**

Crowns, jackets, inlays, onlays and cast restorations are benefits on the same tooth only once every five years.

## **IV. Prosthodontic Benefits – 80%**

Construction or repair of fixed bridges, partial dentures and complete dentures are benefits if provided to replace missing, natural teeth.

### **Limitations**

- a) Prosthodontic appliances are benefits only once every five (5) years unless Delta determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory.
- b) Delta will pay the above percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance. This fee allowance is the fee that would satisfy the majority of Delta's Dentists. A standard partial or complete denture is one made from accepted materials and by conventional methods. The maximum fee allowance is revised periodically, as dental fees change. If your dentist's accepted fee on file with Delta for a partial or complete denture is higher than this maximum allowance, you must pay that

portion of his or her fee that exceeds Delta's allowance in addition to your portion of the allowance.

- c) Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your program. However, if implants are provided along with a covered prosthodontic appliance, Delta will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If Delta makes such an allowance, we will not pay any replacement for five years following the completion of the service.

#### **V. Orthodontic Benefits – 50%**

Delta Dental agrees to provide Orthodontic Benefits to eligible dependent children only. Orthodontics are the procedures performed by a licensed Dentist, involving surgical repositioning of the teeth or jaws in whole or in part and/or use of an active orthodontic appliance. This includes post-treatment retentive appliances for treatment of mal-alignment of teeth and/or jaws, which significantly interferes with their function. Delta Dental will pay or otherwise discharge 50% of the lesser of the UCR fees or of the fee actually charged for the Orthodontic services. *The lifetime maximum amount payable by Delta Dental for all Orthodontics whether paid for under the provisions of this contract or under any prior dental care plan rendered to eligible dependent children shall be \$2,000.*

#### **Exclusions and Limitations**

- a) The obligation of Delta Dental to make payments for orthodontic treatment plan begun prior to the eligibility date of the patient shall commence with the first payment due following the patient's eligibility date. The above-mentioned maximum amount payable will apply fully to this and subsequent payments.
- b) The obligation of Delta Dental to make payments for orthodontics shall terminate on the payment due next following the date the dependent loses eligibility or the employee loses eligibility, or upon the termination of treatment for any reason prior to completion of the case, or upon termination of the contract, whichever shall occur first.
- c) Delta Dental will not make any payment for repair or replacement of an orthodontic appliance furnished, in whole or in part, under this plan.
- d) X-rays and extraction procedures incident to orthodontics are not covered by orthodontic benefits, but may be covered under the provisions of the attached contract, subject to all of the terms and provisions thereof.
- e) Delta Dental will pay the applicable percentage of the dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If the enrollee selects specialized orthodontic appliances or procedures, an allowance will be made for the cost of the standard orthodontic treatment plan and the patient is responsible for the remainder of the dentist's fee.

#### **General Limitation**

This limitation applies to all Benefits as set forth in section I., II., III., IV. And V., above. If an Enrollee selects a more expensive plan of treatment than is customarily provided or specialized techniques rather than standard procedures, Delta will pay the applicable percentage of the lesser

fee for the customary or standard treatment and the patient is responsible for the remainder of the dentist's fee.

For example: a crown where a silver filling would restore the tooth; a gold crown where one constructed of semiprecious materials would restore the tooth; or a precision denture where a standard denture would suffice.

### **Exclusions/Services we do not cover**

Delta covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your dentist.

Delta does not provide benefits for:

1. Services for injuries covered by Worker's Compensation or Employer's Liability Laws or services which are paid by any federal, state or local government agency, except Medical benefits.
2. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
3. Treatment which restores tooth structure that is worn; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or treatment which stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.
4. Any Single Procedure, bridge, denture or other prosthodontic service which was started before you were covered by this program.
5. Prescribed drugs, premedication or analgesia.
6. Experimental procedures.
7. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
8. Anesthesia, except for general anesthesia given by dentist for covered oral surgery procedures.
9. Grafting tissues from outside the mouth to tissue inside the mouth ("extraoral grafts"), implants (materials implanted into bone or soft tissue) or the removal of implants.
10. Services for any disturbances of the jaw joints (temporomandibular joints "TMJ") or associated muscles, nerves or tissues.
11. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
12. Diagnostic casts.

### **Saving Money on Your Dental Bills**

You can keep your dental expenses down by:

1. Comparing the fees of different dentists;
2. Using a Delta Dentist;

3. Having your dentist obtain predetermination from Delta for any treatment over \$300;
4. Visiting your dentist regularly for checkups;
5. Following your dentist's advice about regular brushing and flossing;
6. Not putting off treatment until you have a major problem and;
7. Learning the facts about over billing. Under this program, you must pay the dentist your co-payment share (see "Your Benefits" above). You may hear of some dentists who offer to accept insurance payments as "full payment." You should know that these dentists may do so by overcharging your program and may do more than you need, thereby increasing program costs. You can help keep your dental benefits intact by avoiding such schemes.

### **Predeterminations**

After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than \$300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta will pay if you are eligible and meet all the requirements of your program at the time the treatment you have planned is completed.

In order to receive a predetermination, your dentist must send an Attending Dentist's Statement to us listing the proposed treatment. Delta will send your dentist a Notice of Predetermination which estimates how much of the treatment costs we will pay and how much you will have to pay. After you review the treatment plan, your dentist returns the statement to us for payment.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

### **Payment**

Delta will pay Delta Dentists directly. Our agreement with our Delta Dentists makes sure that you will not be responsible to the dentist for any money we owe. However, if for any reason we fail to pay a dentist who is not a Delta Dentist, you may be liable for that portion of the cost. If you have selected a non-Delta Dentist, Delta will pay you. (Payments made to you are not grant requests to pay non-Delta Dentists directly).

Delta does not pay Delta Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

Payment for any single procedure which is a covered service will only be made upon completion of that procedure. Delta does not make prorated payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any deductible (and determines when a charge is made against any maximum) under your program.

If there is a difference between what your dentist is charging you and what Delta says your portion should be, or if you are not satisfied with dental work you have received, contact Delta's Customer and Member Service Department. We may be able to help you resolve the situation.

Delta may deny payment of an Attending Dentist's Statement for services submitted more than six months after the date the services were provided. If a claim is denied due to a Delta Dentist's

failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by Delta (unless you failed to advise the dentist of your eligibility at the time of treatment).

The processes Delta uses to determine or deny payment for services are distributed to all Delta Dentists. They describe in detail the dental procedures covered as Benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the program. Claims are reviewed for eligibility and are paid according to these processing policies. Those claims which require additional review are evaluated by Delta's Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta's Customer and Member Service Department for more information regarding Delta's processing policies.

### **Second Opinions**

Delta obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

Delta will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Predetermination of treatment cost by a dentist. Delta will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. Delta will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta to perform the clinical examination. When Delta authorizes a second opinion through a Regional Consultant, it will pay for all charges.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examination or consultation may be submitted to Delta for payment. Delta will pay such claims in accordance with the Benefits of the program.

This is only a summary of Delta's policy on second opinions. A copy of Delta's formal policy is available from Delta's Customer and Member Service Department upon request.

### **Dual Coverage**

Be sure to advise your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the Attending Dentist's Statement, so that you will receive all benefits to which you are entitled. For further information, contact the Delta Customer and Member Service Department.

FOR ADDITIONAL INFORMATION ABOUT THE DELTA DENTAL PROGRAM, INCLUDING LIMITATIONS AND EXCLUSIONS, REFER TO YOUR *EVIDENCE OF COVERAGE* BOOKLET (CALLED AN "EOC") PROVIDED BY DELTA DENTAL.

Delta Dental  
Customer Service  
P.O. Box 997330  
Sacramento, CA 95899-7330  
Member Services: (800) 765-6003  
E-Mail: [cms@delta.org](mailto:cms@delta.org)  
Web Site: [www.deltadentalins.com](http://www.deltadentalins.com)

## VISION BENEFITS

The Plan's Vision Benefits are administered through Vision Service Plan ("VSP"). While you can go to any vision care professional you want, the thousands of VSP opticians enrolled have agreed to accept VSP's fee schedule, so the amount of your claim that will be covered by the Plan is likely to be higher if you use a VSP provider.

### SUMMARY OF BENEFITS

	<i>Services from a VSP Participating Provider</i>	<i>Services from a Non- Participating Provider</i>
<b>General Summary</b>		
Examination	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contacts**	Once every 12 months	
<b>Co-Payment</b>	None	A co-payment may apply
Examination	Paid-in-Full	up to \$45.00
Single Vision Lenses	Paid-in-Full within VSP allowance	up to \$45.00
Bifocal Lenses	Paid-in-Full within VSP allowance	up to \$65.00
Trifocal Lenses	Paid-in-Full within VSP allowance	up to \$85.00
Lenticular or Aphakic Lenses	Paid-in-Full within VSP allowance	up to \$125.00
Frames	Covered up to VSP allowance	up to \$80.00
<b>Contact Lenses**</b>		
Medically Necessary*	Paid-in-Full	up to \$210.00
Cosmetic or Convenience	up to \$120.00	up to \$120.00
<b>Second Pair Eyewear Benefit</b>		
Lenses	Once every 12 months	
Frames	Once every 24 months	
<b>Co-Payment</b>	\$20	
Single Vision Lenses	Paid-in-Full within VSP allowance	up to \$45.00
Bifocal Lenses	Paid-in-Full within VSP allowance	up to \$65.00
Trifocal Lenses	Paid-in-Full within VSP allowance	up to \$85.00
Lenticular or Aphakic Lenses	Paid-in-Full within VSP allowance	up to \$125.00

	<i>Services from a VSP Participating Provider</i>	<i>Services from a Non-Participating Provider</i>
Frames	Covered up to VSP allowance	up to \$80.00
Contact Lenses*		
Medically Necessary	Paid-in-Full within VSP allowance	up to \$210.00

\*Your doctor must obtain prior approval for medically necessary contact lenses from VSP.

\*\*This benefit is in addition to the comprehensive eye examination, but in lieu of lenses and frames. If contact lenses are for cosmetic or convenience purposes, the Plan will pay up to \$120.00 toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility.

If contact lenses are medically necessary, they are a fully covered benefit: following cataract surgery, or when necessitated by anisometropia or certain conditions of keratoconus. **PRIOR AUTHORIZATION FROM VISION SERVICE PLAN (VSP) IS REQUIRED.**

### **HOW TO USE THE PLAN**

**STEP ONE:** Call a VSP participating provider to make an appointment. For details on how you locate a VSP Participating Provider call VSP at (800) 877-7195 to request a Participating Provider listing, or visit VSP’s website at [www.vsp.com](http://www.vsp.com). Make sure you identify yourself as a VSP member, and be prepared to provide the VSP member’s Social Security Number.

**STEP TWO:** The VSP participating provider will contact VSP to verify your eligibility and plan coverage, and will also obtain authorization for services and materials. If you are not currently eligible for services, the VSP participating provider is responsible for communicating this to you. VSP will pay the participating provider directly for covered services and materials.

**STEP THREE:** The VSP participating provider will contact you to confirm eligibility and your appointment. The provider will bill VSP for the cost of covered services

When you are examined and/or you receive materials from a VSP participating provider, the patient has no out-of-pocket expenses other than the co-payment (if any – see the chart above) and the cost of any materials (lenses, frames, etc.) that exceed the VSP allowance.

### **USING A NON-VSP PROVIDER**

Services and materials obtained from a non-participating provider will be reimbursed up to amounts on the above schedule. If you receive an examination and/or materials from a non-VSP provider, you are responsible for paying the provider in full and submitting itemized receipts to VSP for reimbursement, Attn: Out-of-Network Claims at P.O. Box 997105, Sacramento, CA 95899-7105. It is important to note that the reimbursement schedule does not guarantee full payment.

**LOW VISION CARE BENEFIT**

The Low Vision Benefit is available to participating members who have severe visual problems that are not correctable with regular lenses and is subject to prior approval by VSP.

<b>General Summary</b>	<i>Services from a VSP Participating Provider</i>	<i>Services from a Non-Participating Provider</i>
Supplementary Testing – Complete low vision analysis/ diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.	Covered in Full up to VSP Allowance	Up to \$125.00
Supplemental Care Aids – Subsequent low vision aids as Visually Necessary or Appropriate.	75% of Cost	75% of Cost
Co-Payment for Supplemental Aids	25% payable by Covered Person	
Benefit Maximum	The maximum benefit available is \$1,000.00 (excluding co-payment) every two years	

**Non-Participating Provider Benefit**

Low Vision benefits secured from a Non-Participating Provider are subject to the same time limits and co-payment arrangements as described above for a Participating Provider. The participating member should pay the Non-Participating Provider his full fee. The participating member will be reimbursed in accordance with an amount not to exceed what VSP would pay a Participating Provider in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% co-payment feature.

**BENEFITS SUBJECT TO LIMITATION UNDER THE VISION PROGRAM**

Cosmetic Options:

- Blended lenses
- Contact lenses (except as noted elsewhere)
- Scratch coating
- Anti-reflective coating
- UV protected lenses
- Oversized lenses (over 60mm)
- Progressive multifocal lenses (Progressive J and K/CR-39 Plastic or Glass and Progressive Flat Top/Smart Seg only)
- All other progressive multifocal lenses

- Photochromic or tinted lenses other than Pink 1 or 2 (unless elected by your group)
- Other coated or laminated lenses
- Certain limitations on low vision care – \$1,000.00 benefit maximum (excluding co-payment) every two (2) years
- Cosmetic lenses
- Optional cosmetic processes

**EXCLUSIONS: WHAT IS NOT COVERED?**

- Orthoptics or vision training and any associated supplemental testing
- Non-prescription lenses
- Two pairs of glasses instead of bifocals
- Complete pairs of glasses furnished under this program that are lost or broken (except at the normal intervals when services are otherwise available)
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an employer as a condition of employment
- Experimental vision services, treatments, and materials

Vision Service Plan  
3333 Quality Drive  
Rancho Cordova, CA 95670  
Customer Service: (800) 877-7195  
Web Site: [www.vsp.com](http://www.vsp.com)

THIS IS A BRIEF OUTLINE OF THE PLAN AND IS NOT TO BE ACCEPTED OR CONSTRUED AS A SUBSTITUTE FOR PROVISIONS OF THE CONTRACT.

# LIFE INSURANCE

Life insurance coverage is provided pursuant to an insurance policy with the Union Labor Life Insurance Company and is limited to Active Members and their Dependents. Retirees and their Dependents are *not* eligible for Life Insurance coverage.

## SCHEDULE OF BENEFITS

For Active Members only

Life Insurance	\$50,000
Accidental Death and Dismemberment	\$50,000

Life Insurance for Dependents of Active Members

Member's spouse	\$1,000
Child 3 years to 19 years*	\$500
Child 2 years to 3 years	\$400
Child 6 months to 2 years	\$200
Birth to 6 months	\$100

\*To age 26 if child is mentally or physically handicapped or is a full-time student in school.

## CONVERSION OF YOUR GROUP LIFE INSURANCE TO INDIVIDUAL COVERAGE

If your insurance terminates for any reason, a Life Insurance conversion policy is available without medical examination, provided the Trust Fund's Group Master Policy is in force when you are no longer eligible for insurance. **You have thirty-one (31) days after termination of your group insurance to make application and pay the required premium for such policy.** The conversion policy shall become effective on the date following the date your group insurance terminates. This conversion policy is available to your spouse in the event of your death. In addition, any of your children who cease to be eligible for coverage under this Group Plan may convert to an individual policy. All you have to do is apply directly to the Insurance Company and pay the premium for your attained age. No medical examination will be required.

Conversion applications can be obtained from the Trust Fund Office.

## PAYMENT AND FORM OF BENEFIT

The amount of your Life Insurance as shown in the Schedule of Benefits will be paid in the event of your death from any cause. Arrangements may be made to have the proceeds of the insurance paid in installments.

## DESIGNATION OF THE BENEFICIARY OF YOUR LIFE INSURANCE

You may name anyone you desire as your beneficiary and you may change your beneficiary at any time. A beneficiary may be changed by contacting the Trust Office Fund at (415) 626-2000 to obtain an Enrollment/Change form. Please return the updated enrollment/change form to the Trust Fund Office for processing. The most recent Enrollment/Change form on file will be used in determining the beneficiary when a claim has been filed.

## **EXTENDED ELIGIBILITY IN THE EVENT OF TOTAL DISABILITY**

If you become totally disabled before your 60th birthday and your disability prevents you from engaging in any work for which you are qualified by reason of education, training or experience for an extended period of time, your insurance will be kept in force without further cost for as long as you continue to be totally disabled.

For purposes of the Life Insurance Benefit, “Total Disability” means the person’s complete inability, due to injury or illness, to engage in any business, occupation, or employment, even on a part-time basis, for which the person is qualified or becomes qualified by reason of education, training or experience, for pay, profit or compensation.

To qualify for this Total Disability Waiver of Premium Benefit, you, or someone on your behalf, must give written proof satisfactory to the Insurance Company that you are totally disabled. The Insurance Company must receive this proof at its Home Office between the 9th and 12th month after the date you stop being actively at work. If the Company does not receive the proof before the end of the 12th month, your Life Insurance will not be continued.

**THIS IS ONLY A SUMMARY OF YOUR BENEFITS. PLEASE CONTACT THE TRUST FUND ADMINISTRATION OFFICE FOR A COPY OF THE POLICY CERTIFICATE WHICH INCLUDES A BINDING AND DETAILED DESCRIPTION OF BENEFITS, EXCLUSIONS AND LIMITATIONS.**

Union Labor Life Insurance Company  
8403 Colesville Road, 13<sup>th</sup> Floor  
Silver Spring, MD 20910  
Phone: (202) 682-6768  
[www.ullico.com](http://www.ullico.com)

## **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

Accidental Death and Dismemberment coverage is provided pursuant to an insurance policy with the Union Labor Life Insurance Company and is limited to Active Members and their Dependents. Retirees and their Dependents are *not* eligible for this coverage. The amount of insurance shown in the Schedule of Benefits will be paid in a lump sum to the beneficiary named by you in the event of your death as a result of accidental bodily injury; or to you in the event of loss as a result of accidental bodily injury of any of the following or combinations thereof; sight of both eyes, both hands, both feet.

One-half (1/2) of the amount of insurance will be paid to you in the event of loss as a result of accidental bodily injury of one hand, or one foot, or of the sight of one eye.

No more than the total amount of your insurance will be paid for all losses combined resulting from the same accident.

### **LOSSES NOT COVERED**

- Loss occurring more than ninety (90) days after the accident.
- Loss resulting from:
  - a) Physical or mental infirmity, or disease of any kind,
  - b) Intentional self-inflicted injury or suicide while sane or insane, and/or
  - c) Insurrection or war, or any act incident thereto.

### **NOTICE OF CLAIM**

In the event of accidental death, immediate notice must be given to the Trust Fund Office. In the event of accidental death, the Company may make an autopsy unless prohibited by law. All other provisions regarding such notice are explained elsewhere in this Handbook.

**THIS IS ONLY A SUMMARY OF YOUR BENEFITS. PLEASE CONTACT THE TRUST FUND OFFICE FOR A COPY OF THE POLICY CERTIFICATE WHICH INCLUDES A BINDING AND DETAILED DESCRIPTION OF BENEFITS, EXCLUSIONS AND LIMITATIONS.**

## WEEKLY ACCIDENT AND SICKNESS BENEFITS

Weekly accident and sickness benefits are limited to Active Members and their Dependents [NOTE: Please determine if Dependents are covered by this benefit]. Retirees and their Dependents are *not* eligible for this coverage.

### ACCIDENT BENEFIT

Weekly payments of \$75 will be made to you beginning with the first (1<sup>st</sup>) day of disability due to an accident.

### SICKNESS BENEFIT

Weekly payments of \$75 will be made to you beginning with the eighth (8<sup>th</sup>) day of disability due to sickness or a pregnancy.

Maximum number of weeks for which benefits are payable for any one disability is **twenty-six (26) weeks**.

There is no limit to the number of times a year that any member may receive Accident or Sickness Benefits.

When you have successive periods of disability, they will be considered separate periods, provided they are unrelated. If the periods of disability are related, they must be separated by at least fourteen (14) days of active work or availability for work. For purposes of this benefit, a “disability” is a complete inability, due to illness or injury, to engage in any business, occupation, or employment, even on a part-time basis, for which you are qualified or become qualified by reason of education, training or experience, for pay, profit or compensation.

### CONDITIONS NOT COVERED

Any injury or sickness for which you are not under the care of a licensed physician or surgeon, and elective abortion. However, benefits will be payable for any disability due to complications which are the result of an elective abortion.

“Elective Abortion” means any abortion other than one where the mother’s life would be endangered if the fetus were carried to term.

### RECUPERATION BENEFITS

If within four (4) weeks of release from hospital confinement for which benefits have been paid under the Hospital Benefits provision of the policy for inpatient confinement and upon the recommendation of the attending physician, you are confined in a facility authorized jointly by the insurance carrier for the purpose of recuperation from the sickness or injury which caused the hospital confinement, payment will be made for accommodations and miscellaneous services. The maximum aggregate benefit payable in any calendar year for such accommodations and services shall not exceed **six (6) weeks**. Certification by the attending physician of the need for continuing confinement must be provided for each two (2) week period of confinement.

### SUCCESSIVE CONFINEMENTS

Benefits, up to the maximum of six (6) weeks in any calendar year, are available to you for each confinement if the causes are different. However, if successive confinements are due to the same

cause, separate benefits are available if you have returned to active work on a full-time basis for at least one day, or a complete recovery has taken place between them.

#### **BENEFITS FOLLOWING CANCELLATION**

Benefits will be paid for a confinement which occurs within three (3) months following cancellation of your insurance provided the confinement occurs during a period of total disability which has been continuous from the date your insurance canceled.

#### **LIMITATIONS**

No benefits will be paid for confinements due to: a) occupational accidents, b) sickness covered by workers' compensation, c) confinement starting before your insurance becomes effective, d) war or act of war, e) mental and nervous disorders, or f) alcoholism or drug addiction.

# HOW TO FILE A CLAIM

## HOW TO FILE A CLAIM FOR MEDICAL BENEFITS

See your Health Net or Kaiser *Explanation of Coverage* (“EOC”). If you do not have an EOC ask the Trust Fund Office.

## HOW TO FILE A CLAIM FOR DENTAL BENEFITS

Delta Dental will provide notifications if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for denial. If you have a question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures and operations of Delta, or the quality of dental services performed by a Delta Dentist, you may contact our Customer and Member Service Department. You have sixty (60) days after you receive notice of denial to appeal. If you write, you must include the name of the patient, the group number, the Eligible Employee’s name and social security number or identification number, and your telephone number on all correspondence. You should also include a copy of the treatment form, Notice of Payment and any other relevant information. Clearly explain your complaint and send it to us at the address provided in the handbook.

Delta Dental will review your complaint and will respond to it within thirty (30) days unless more information or time is needed to resolve the matter. We may need more time if your complaint is referred to a dental consultant or to a peer review committee of the local dental society. If a referral is necessary, a reply will be sent to you no more than one hundred and twenty (120) days after we receive your complaint. We will respond within five (5) days of receipt to complaints involving imminent and serious threat to a patient’s health.

You may file a complaint with the Department of Corporations after you have completed Delta’s grievance process or after you have been involved in Delta’s grievance process for sixty (60) days. You may file a complaint with the Department immediately in an emergency situation which is one involving imminent and serious threat to your health.

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free number (888) 466-2219 to receive complaints regarding health plans. If you have a grievance against the health plan, you should contact the plan and use the plan’s grievance process. If you need the Department’s help with a grievance that has not been satisfactorily resolved by the plan, you may call the Department’s toll-free telephone number.

Disputes relating to your plan, including claim denials, may be settled by arbitration if they cannot be settled by this complaint process. Arbitration will follow the Commercial Rules of the American Arbitration Association (“AAA”). You can begin this process by giving written notice to each party (for example, Delta and your dentist) with whom you want to arbitrate, explaining the dispute and the amount involved, if any, and the solution you wish. You must then file two (2) copies of the notice with the Association’s regional office in Los Angeles, or San Francisco, along with the fee required by the Association.

In the event of extreme hardship on the part of an Enrollee or subscriber, and upon an application for relief presented to the AAA, Delta shall assume all or a portion of the arbitration fees and expenses as determined by the AAA in accordance with procedures established and administered by the AAA.

### **HOW TO FILE A CLAIM FOR PRESCRIPTION DRUG BENEFITS**

You will need to file a claim only if you have used a non-participating retail pharmacy.

A claim form is necessary and available by going to [www.envisionrx.com](http://www.envisionrx.com), or by calling Envision RX at (800) 361-4542. You will need only to mail in a completed claim form with the tag that accompanies your prescriptions, and the receipt. The tag must include the name of the patient, the date of purchase, the drug's name/strength, the quantity, the price, pharmacy name/address and prescribing physician. You must file your claim within ninety (90) days.

Send your claim to Envision RX Options, Inc. at the following address:

Envision/Rx Options, Inc.  
2181 East Aurora Road,  
Suite 201  
Twinsburg, Ohio 44087

### **HOW TO FILE A CLAIM FOR VISION BENEFITS**

If you use a VSP provider, you do not need to file a claim form. You will pay the amount due at the end of your visit, and your provider will take care of billing VSP for the remainder.

If you use a non-VSP provider, you will need to file a claim for reimbursement of the applicable amount. 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](http://www.vsp.com) and print it out*). Mail the completed form with your itemized receipt to VSP at the following address:

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

If you have any questions about submitting your claim, contact VSP directly.

### **HOW TO FILE A CLAIM FOR LIFE, AD&D BENEFITS**

Claims for Life, Survivor Income Insurance or AD&D benefits may be sent to the Fund Administrator, on forms available from the Trust Fund Administrator. The claims and appeal process is described above, in the Life, AD&D and Survivor Income section of this booklet. Appeals of the claims for Life or AD&D benefits should be submitted to the Trust Fund Administrator for transmission to the insurance company.

### **TIMELY SUBMIT YOUR CLAIMS**

Unless you go to a provider outside of the Health Net PPO, Health Net HMO or Kaiser HMO Programs, you are unlikely to be required to file a medical claim form. Claims and appeals

procedures applicable to Health Net and Kaiser are contained in their *Explanation of Coverage (EOC)*. If you receive dental coverage from a Dentist who is not a Delta dentist, obtain prescription drugs from a non-Envision Rx Options pharmacy or receive vision care from a non-VSP optician, you must submit a claim form. All claims must be submitted as soon as possible after you receive your services. Medical and dental claims received more than **ninety (90) days** after the date of service will be denied as untimely. Prescription drug claims will be denied if not filed within **ninety (90) days** of purchase. If your claim is for Life, Survivor Income or AD&D benefits, a claim filed more than twelve (12) months from the date the benefit accrued will be denied unless you can show that there was reasonable cause for your delay. In such cases, Union Labor Life Insurance Company may require you to provide proof substantiating the reason for delay.

## **DECISION ON YOUR CLAIM**

The claims procedure you follow will depend on whether your claim for benefits is a claim involving urgent care, a pre-service claim, or a post-service claim.

A pre-service claim is any claim for services not yet performed, which are not for urgent care. An urgent care claim is a claim for medical care or treatment if delays could seriously jeopardize your life or health or your ability to regain maximum function, or would, in the opinion of your physician, subject you to severe pain that can only be effectively managed through the requested course of treatment. Any claim for health care benefits under the Plan that is not an urgent care claim, a pre-service claim, or a concurrent care claim (see below) is considered a post-service claim.

### **Pre-Service Claims**

For purposes of any pre-service claims not reserved to Health Net, Kaiser, Delta Dental, or VSP's responsibility, the Trust Fund will issue a decision within fifteen (15) days after receipt of the claim. If an extension is necessary, then a decision will be issued within 30 days. You will receive written notice of the extension before the end of the initial 15-day period, which will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the required information, and you will have forty-five (45) days to provide the requested information. The time period in which a decision will be issued is delayed from the date the extension was sent out until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

### **Urgent Care Claims**

For purposes of any urgent care claims not reserved to Health Net, Kaiser, Delta Dental, or VSP's responsibility, the Trust Fund will issue a decision as soon as possible and within seventy-two (72) hours after receipt of the claim. If more information is required to determine the claim, you will be notified as soon as possible but within twenty-four (24) hours, and given at least forty-eight (48) hours to provide the requested information. If you do not provide the requested information within the 48-hour period, your claim will be denied.

### **Post-Service Claims**

For purposes of any post-service claims not reserved to Health Net, Kaiser, Delta Dental, or VSP's responsibility, the Fund will issue a decision within thirty (30) days after receipt of the

claim, unless an extension is necessary, in which case a decision will be issued within forty-five (45) days. Written notice of the extension will be provided to you before the end of the initial 30-day period and will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the required information, and you will have forty-five (45) days to provide the requested information. The time period in which a decision will be issued is delayed from the date the extension was sent out until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied. FOR THIS PURPOSE A CLAIM FOR ELIGIBILITY WILL BE DEEMED BY THE TRUST FUND A POST-SERVICE CLAIM.

### **Concurrent Care Claims**

For purposes of any concurrent care claims not reserved to Health Net, Kaiser, Delta Dental, or VSP's responsibility, where health care treatment is reduced or terminated before the end of the approved period of time or number of treatments, the Fund will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision if you choose to do so and have the appeal decided before the benefit is reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies. If the request involves urgent care, any claim to extend a course of treatment will be decided as soon as possible but within twenty-four (24) hours, provided the claim is submitted at least twenty-four (24) hours prior to the prescribed end of the course of treatments.

### **Claims for Life Insurance and AD&D**

Union Labor Life Insurance Company will issue a decision within ninety (90) days after receipt of the claim, unless an extension is necessary, in which case a decision will be issued within 180 days. Written notice of the extension will be provided to you before the end of the initial 90-day period and will state the reason(s) for the extension and the date you can expect a decision.

### **EXPLANATION FOR DENIAL OF A CLAIM FOR MEDICAL, PRESCRIPTION DRUG OR DENTAL BENEFITS**

After you file a claim or request pre-authorization (following the procedures listed in the preceding chapters) the Delta Dental, Envision Rx Options or VSP may deny all or a part of your claim or request. You may seek review of that decision by Delta Dental, Envision Rx Options or VSP, and in the event the claim is still denied, you may then appeal the decision to the Board of Trustees as described below. There are a number of reasons why the Fund may deny your claim, most frequently because the individual receiving treatment is not eligible under the Fund, the claim is submitted late, or because the treatment provided is not covered under the terms of the Plan.

If your claim or request is denied, the Trust Fund will send you a letter stating the reason your claim was denied and informing you of the steps you must take to appeal the denial. This letter is referred to as a "notice of adverse decision." The notice will inform you of:

- the reason for the denial of your claim or request, with a reference to the Plan provision(s) that requires denial of your claim,
- any additional information that the Plan requires before it can make a final determination of your claim or request and an explanation of why the Plan needs the information,
- the steps you must take if you choose to appeal the denial, including the applicable time limits for submitting an appeal and your right to submit written comments, documents and other information relating to the claim,
- your right to request, free of charge, access to any copies of any records or documents that it has in its possession that are relevant to your claim,
- your right to request from the Plan a copy of any internal rule, guideline or protocol that it relied on to decide your claim,
- if your claim is denied because of a lack of medical necessity or the use of experimental or investigational treatment, or other similar exclusion or limit, you will be provided free of charge an explanation of the scientific or clinical judgment for the determination as applied to the Plan or your claim,
- a description of the expedited review process if you were denied an urgent care or urgent pre-authorization request, and
- your rights under ERISA to bring a civil action following a denial of a claim on appeal.

## CLAIMS APPEALS PROCEDURES

**If you disagree with the Trust Fund's reason(s) for denying your claim or request, you may appeal the decision to the Board of Trustees. If you disagree with Health Net or Kaiser's denial of treatment or coverage you should follow the appeal procedures contained in your *Explanation of Coverage (EOC)*.** When you appeal a decision it means the Board of Trustees will review and reconsider the Plan's initial determination.

To appeal a claim you must send a written statement to the Trust Fund Office within **one hundred and eighty (180) days** of receiving a notice of adverse decision on your claim for benefits and/or request for pre-authorization. If you (or your authorized representative) do not appeal the decision within **one hundred and eighty (180) days**, you lose your right to appeal the decision and also your right to sue because you have not exhausted your administrative remedies. If you have a good reason for failing to appeal a decision within the above period, you may file an appeal for up to one year after the denial, but you must show in your appeal that you had good cause for filing a late appeal.

Your written statement of appeal must describe in detail your claim for benefits and the reason why you believe your claim was improperly denied. In addition, the statement must include any documents you believe are pertinent to your appeal (and were not already provided to the Fund with your original claim).

All claims other than pre-service or urgent care claims will be decided at the next regularly scheduled meeting of the Board of Trustees if the Plan receives your appeal at least thirty (30) days in advance of the next Board Meeting. If your appeal is not received within thirty (30) days of the next Board of Trustees' meeting, your appeal will be decided at the second regularly scheduled Board of Trustees' meeting following receipt of your appeal. If the Board requires additional time because of exceptional circumstances, within sixty (60) days of receiving your appeal, the Plan will send you a notice extending the time to decide your appeal. Even with an extension of time, the Board of Trustees will not take longer than **one hundred and twenty (120) days** to decide your appeal.

The Board of Trustees will make a decision on your appeal, and may appoint at least one Employer Trustee and one Union Trustee to hear your appeal, who will then make a recommendation to the entire Board of Trustees for final determination. The Board of Trustees will not defer to the initial adverse benefit determination and will consider all comments, documents and records, and other information you timely provide, even if they were not received or considered during the initial claim decision. The Board of Trustees' decision on your appeal will be made on the basis of the record, including any additional documents and comments you send. If the Plan denied your claim on the basis of medical necessity, the Board of Trustees will consult a health care professional with training and expertise applicable to the relevant field of medicine. Upon request, you can obtain the name of any health care professional consulted and the advice given, if any, concerning your claim.

### APPEALING PRE-SERVICE AND URGENT CARE CLAIMS

Different procedures apply to **pre-service** and **urgent care health claims**. For pre-service claims, the Board of Trustees will decide your appeal within thirty (30) days. You may also

request expedited review of urgent care claim denials by telephone or in writing and submit information in support of your appeal by facsimile and/or telephone, as appropriate.

For such claims you may appeal an adverse decision by calling the Trust Fund Administrator at (415) 626-2000, and by faxing your letter of appeal or supporting documents to (415) 626-2090.

You will receive notice of the decision within seventy-two (72) hours of receipt of the appeal.

### **THE DECISION ON APPEAL**

After the Board of Trustees decides your appeal, the Plan will send you a written notice of the decision, which will include:

- the reasons for the decision and references to the Plan's rules that justify the Board of Trustees' decision,
- a statement of your right to receive, upon your request and free of charge, access to and copies of all documents, records and other relevant information,
- your right to file suit under section 502(a) of ERISA,
- if your claim is for medical or disability benefits, you will be notified if an internal rule, guideline, or other similar criterion was relied on by the Board of Trustees and will be provided with a copy of such rule, guideline, or other criterion free of charge at your request, and
- if your claim is denied based on a medical necessity or other similar exclusion or limit, at your request you will be provided, free of charge, an explanation of how that exclusion or limit and any clinical judgments apply to your medical circumstances, including information relating to medical or vocational experts whose advice was obtained on behalf of the Board of Trustees in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

You will be notified of the Board of Trustees' decision on your appeal as soon as possible, but no later than five (5) days after the Board has made its decision.

# DEFINITIONS

## ACTIVE EMPLOYEE OR ACTIVE PARTICIPANT

You are an Active Employee or an Active Participant if your continued participation in the Plan is based on the number of hours you work for a Participating Employer bound by a Collective Bargaining Agreement which requires contributions to be made to the Trust Funds on your behalf. You remain an Active Employee if you are on leave or otherwise not actively working provided that the Collective Bargaining Agreement requires your employer to continue to make contributions to the Trust Fund while you are on such leave, and such contributions are in fact made.

## BENEFICIARY

The person or persons you have designated to receive certain Plan benefits that are payable if you die.

## DOMESTIC PARTNER

See page 4.

## LEGAL GUARDIANSHIP

The term “legal guardianship” refers to the court-ordered relationship between a child and a person other than the legal parent resulting in the termination of parental rights and the assumption of responsibility over the child by a non-parent guardian.

## MAINTENANCE MEDICATIONS

Prescription drugs otherwise covered under the terms of the Plan required to stabilize an illness or symptoms of illness. Examples of maintenance medications include, but are not limited to, medications taken for:

- Attention-deficit hyperactivity disorder (ADHD) and attention-deficit disorder (ADD), depression, anxiety, insomnia, psychosis or schizophrenia.
- Diseases of the central nervous system including epilepsy or seizures, Parkinson’s disease, dementia, Alzheimer’s disease or similar memory problems, etc.
- Diabetes, thyroid problems or osteoporosis.
- Heart, circulatory or blood conditions including heart failure, high cholesterol, high blood pressure, stroke, heart attack, blood clots, anemias, etc.
- Some respiratory or lung conditions such as allergies, asthma, etc.
- Certain stomach, bowel or digestive problems including ulcers, heartburn or reflux disease, etc.
- Urinary or prostate problems including, enlarged prostate, etc.
- Some painful conditions such as migraine headaches, gout, some types of arthritis, etc.
- Medications to treat conditions of the eye such as glaucoma, etc.
- Skin or skin-related conditions such as acne, psoriasis, etc.

- Prevention of rejection of transplanted organs or tissues.
- Certain infectious diseases such as tuberculosis and viral diseases such as HIV, hepatitis, etc.

### **MEDICARE**

The benefits provided under Title XVIII of the Social Security Act and all amendments to the Act.

### **OPEN ENROLLMENT PERIOD**

Assigned days in the months of May and June and coverage is effective July 1.

### **PARTICIPATING EMPLOYER**

Any employer or successor in interest to such employer that subscribes to the Trust Agreement and is obligated to contribute to the Plan, contributes to the Plan, and is accepted for Plan participation by the Board of Trustees.

### **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**

Qualified Medical Child Support Order (QMCSO) means a medical support order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law under that state, and which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Plan participant is eligible. The Plan must determine that the order is qualified under the terms of ERISA and applicable state law.

### **RETIREE**

An individual who formerly received benefits under the Plan as an Active Employee, and who has enrolled and meets the eligibility criteria to participate in the Retiree Plan as set forth on page 7.

### **TOTALLY DISABLED OR TOTAL DISABILITY**

You are Totally Disabled, or suffer from a Total Disability, when: (1) you are unable, due to illness, injury or health complications due to pregnancy, to perform your regular and customary work, and (2) you are not working in any gainful employment.

Your Dependant is Totally Disabled, or suffers from a Total Disability, when he or she is completely unable to engage in the normal activities of a person of the same sex or age.

Any two periods of disability will be considered one period of disability, unless you returned to work on a full-time basis for at least two (2) consecutive weeks between the two (2) periods of disability, or the later disability is due to an injury or illness entirely unrelated to the causes of the earlier disability and begins after you have returned to work on a full-time basis.

For purposes of COBRA extended disability coverage, disabled means the Social Security Administration's determination of disability.

**TRUST AGREEMENT**

The Agreement and Declaration of Trust establishing the U.A. Local 38 Health & Welfare Trust Fund and any modification, amendment, extension or renewal thereof.

**TRUST FUND ADMINISTRATION OFFICE OR FUND OFFICE**

The office which performs the day-to-day administration of the Trust Fund and its benefit plans, and which can be reached at 1625 Market Street, San Francisco, CA 94103, (415) 626-2000.

**TRUSTEES OR BOARD OF TRUSTEES**

Trustees or Board of Trustees means the Board of Trustees of the U.A. Local 38 Health & Welfare Trust Fund.

**UNION**

U.A. Local 38.

**YOU**

The Plan participant.

## **OTHER PLAN PROVISIONS**

### **NAME AND ADDRESS OF THE FUND AND THE PLAN**

The U.A. Local 38 Health & Welfare Trust Fund sponsors the U.A. Local 38 Health & Welfare Plan.

1625 Market Street  
San Francisco, CA 94103  
(415) 626-2000

### **PLAN BENEFITS AND THE SOURCE OF FUNDING**

Benefits provided and the premiums payable by the U.A. Local 38 Health & Welfare Trust Fund to benefit providers like Health Net, Kaiser, Delta Dental and VSP are financed entirely by contributions from employers in accordance with the Collective Bargaining Agreement between the employers and U.A. Local 38. The amount of the contribution is determined through the collective bargaining process.

The Board of Trustees has no liability to any individual or entity to provide payment over and above the amounts contributed to the Trust Fund and available for such purposes.

### **TYPE OF FUND**

The Trust Fund is an employee welfare benefit fund and provides medical, dental, vision, prescription drug, mental health, alcohol and chemical dependency treatment, and life insurance benefits for eligible employees and dependents, plus life insurance, accidental death and dismemberment and weekly disability benefits for eligible employees. The benefits are funded and maintained through monthly contributions from participating employers paid on behalf of eligible employees and their covered dependents pursuant to a Collective Bargaining Agreement.

### **FUTURE OF THE FUND AND AMENDMENT OF THE PLAN**

The Trust Fund and all of the Plans it sponsors are established and maintained through the collective bargaining process. The Board of Trustees anticipates that the Plan under which you are covered will continue as long as the Collective Bargaining Agreements so provide or until the Board of Trustees decide to end the Plan or the Trust Fund.

The Board of Trustees reserves the right to change or discontinue any Plan at any time for any reason without need for prior approval by any person, employer or Union. Such amendments may change benefit levels, eligibility requirements – even if the extended eligibility has already been accumulated – or any other provision of the Plan.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim for the benefits occurs.

The Board of Trustees may update the Plan to reflect changes in laws and regulations as well as for any other reason. Any changes to the Plan will not lower amounts already payable for claims incurred before the Plan changes become effective.

Federal law prohibits use of Trust Fund assets for any purpose other than providing benefits and paying the reasonable administrative expenses of the Trust Fund and the Plans it sponsors. If the Trust Fund or Plan(s) end, the remaining assets will continue to provide Plan benefits until there

are no more assets left, or will be used in a way that is consistent with the purpose of the Plan or the Trust Fund. In no event will termination of the Plan and Trust Fund result in the reversion of trust assets to any employer.

#### **DISCLAIMER OF LIABILITY**

The Plan has no control over any diagnosis, treatment, care or lack thereof, or other services delivered to a Plan participant or Dependent by a health care provider (whether a Contract or Non-Contract Provider), and disclaims liability for any loss or injury caused to the Plan participant or Dependent by any provider by reason of negligence, failure to provide treatment or otherwise.

#### **AUTHORITY TO INTERPRET PLAN**

The Trust Agreement gives the Board of Trustees the authority to make any determination of fact necessary and proper to the administration of the Trust Fund and the Plan(s). It also gives the Board of Trustees the power to construe and interpret the rules of the Plan and the Trust Agreement relating to eligibility of covered employees and retirees, their dependents and beneficiaries to receive benefits.

The Board of Trustees shall have the exclusive right, power and authority in their sole and absolute discretion to administer, apply, interpret and/or terminate any provisions of the Plan, this Summary Plan Description, and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the foregoing, the Board of Trustees shall have the sole and absolute discretionary authority to:

- take all actions and make all decisions with respect to eligibility for, and the amount of, benefits payable under the Plan;
- formulate, interpret and apply rules, and policies necessary to administer the Plan in accordance with its terms;
- decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents; and
- process, and approve or deny, benefit claims, and rule on any benefit exclusions.

All determinations made by the Board of Trustees with respect to any matter arising under the Plan, this Summary Plan Description, and any other Plan documents shall be final and binding on all parties. No employer, nor any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board of Trustees, nor can any such person act as an agent of the Board of Trustees. The Board of Trustees have delegated their authority to determine matters arising under the health, prescription drug, dental, vision, life, accidental death and disability and survivor income insurance benefit coverage to Health Net, Kaiser, Delta Dental, Envision Rx Options, Vision Service Plan, and Union Labor Life Insurance Co.

#### **BOARD OF TRUSTEES**

U.A. Local 38 Health and Welfare Trust Fund of San Francisco, Marin, Sonoma, Lake and Mendocino Counties is a Health and Welfare Benefit Plan which is jointly administered by

Trustees who are responsible for the administration of the Plan. The names and addresses of the Trustees are as follows:

Union Trustees

Larry Mazzola, Jr.  
U.A. Local 38 Trust Funds  
1625 Market Street  
San Francisco, CA 94103

Steve Jennings  
U.A. Local 38 Trust Funds  
1625 Market Street  
San Francisco, CA 94103

Bill Blackwell  
U.A. Local 38 Trust Funds  
1625 Market Street  
San Francisco, CA 94103

Frank Reardon  
U.A. Local 38 Trust Funds  
3473 Santa Rosa Avenue  
Santa Rosa, CA 95407

John Chiarenza  
U.A. Local 38 Trust Funds  
1625 Market Street  
San Francisco, CA 94103

Tony Guzzetta  
U.A. Local 38 Trust Funds  
1625 Market Street  
San Francisco, CA 94103

Employer Trustees

Scott Strawbridge  
MCA of Northern California  
P.O. Box 159  
Benecia, CA 94510

Robert E. Buckley, Jr.  
Anderson Rowe & Buckley  
2833 - 3rd Street  
San Francisco, CA 94107

Armand Kilijian  
O'Brien Mechanical  
1515 Galvez Avenue  
San Francisco, CA 94124

Dan Orsot  
OMPP, dba Clausen Patten  
100 North Hill Drive, #2  
Brisbane, CA 94005

Fred Nurisso  
Broadway Mechanical  
873 81<sup>st</sup> Street  
Oakland, CA 94621

Milt Goodman  
ACCO Engineering  
6265 San Fernando Road  
Glendale, CA 91201

**FUNDING OF BENEFITS**

The benefits under the Plan are either self-funded or funded through group contracts between the Trust Fund and the third parties described in the chart below.

Type of Benefit	Name of Provider	Type of Funding
PPO Medical Plan	Health Net	Insured
HMO Medical Benefits	Health Net & Kaiser Permanente	Insured

<b>Type of Benefit</b>	<b>Name of Provider</b>	<b>Type of Funding</b>
Prescription Drugs	Envision Rx Options, Inc.	Self-Funded
Dental	Delta Dental	Insured
Vision	Visions Service Plan	Insured
Life, and Accidental Death & Dismemberment	Union Labor Life Insurance Company	Insured
Weekly Disability Income	None	Self-Funded

**FUND’S EMPLOYER IDENTIFICATION NUMBER AND PLAN YEAR**

The Trust Fund’s Employer Identification Number (EIN) assigned by the Internal Revenue Service is 94-1285319 and its fiscal year is July 1 through June 30.

**COLLECTIVE BARGAINING AGREEMENTS**

The current Collective Bargaining Agreements between U.A. Local 38 and the participating employers require the individual employers to contribute to the Trust Fund at the rate per hour prescribed by the applicable Collective Bargaining Agreement for hours worked by each of their employees upon covered employment. The parties to the Collective Bargaining Agreement are:

- Mechanical Contractors Association of Northern California, Inc.;
- Master Plumbers Association of San Francisco, Inc.; and
- Local Union 38 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada.

A copy of the specific provisions of the Collective Bargaining Agreement applicable to Health & Welfare Benefits is available from either the Trust Fund Administration Office or the U. A. Local 38 office.

If you have a question whether a specific employer is a sponsor of the Plan, you may request in writing the information from the Trust Fund Administrative Office.

**AGENT FOR SERVICE OF LEGAL PROCESS**

The Agent for Service of legal process on the Trust Fund is:

Albert Brundage, Attorney-at-Law  
1621 Market Street  
San Francisco, CA 94103  
(415) 626-2000

Service of legal process may also be made on the Board of Trustees or upon any member of the Board of Trustees.

**ELIGIBILITY FOR PARTICIPATION AND BENEFITS**

The Plan’s requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or loss of benefits are described beginning on page 2 of this Handbook.

The benefits are provided by contracts with the following insurance companies and insurance service organizations:

- Health Net PPO
- Health Net HMO
- Kaiser Foundation Health Plan
- Envision Rx Options Pharmacy Program
- Delta Dental Service
- Vision Service Plan
- Union Labor Life Insurance Co.

**REQUEST FOR INFORMATION AND DOCUMENTS**

All requests for information and correspondence relative to coverage, benefits and interpretation of the U.A. Local 38 Health & Welfare Trust Fund and all requests for documents should be made in writing to:

U.A. Local 38 Health & Welfare Trust Fund  
 1625 Market Street  
 San Francisco, CA 94103  
 (415) 626-2000

**CONTACT INFORMATION FOR PLAN PROVIDERS**

<i>Plan Provider</i>	<i>Contact Information</i>
Health Net PPO	Health Net Attn: PPO Customer Service P.O. Box 9103 Van Nuys, CA 91409 (800) 522-0088 <a href="http://www.healthnet.com">www.healthnet.com</a>
Health Net HMO	Health Net Attn: HMO Customer Service P.O. Box 9103 Van Nuys, CA 91409 (800) 522-0088 <a href="http://www.healthnet.com">www.healthnet.com</a>
Kaiser Foundation Health Plan	California Service Center P.O. Box 232400 San Diego, CA 92193-2400 (800) 464-4000 <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a>
Envision Rx Options Pharmacy Program	Envision Pharmaceutical Services, Inc. 2181 East Aurora Road, Suite 201 Twinsburg, OH 44087 (800) 361-4542 <a href="http://www.envisionrx.com">www.envisionrx.com</a>

<i>Plan Provider</i>	<i>Contact Information</i>
Delta Dental Service	Customer Service P.O. Box 997330 Sacramento, CA 95899-7330 Member Services: (800) 765-6003 E-Mail: <a href="mailto:cms@delta.org">cms@delta.org</a> Web Site: <a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
Vision Service Plan	3333 Quality Drive Rancho Cordova, CA 95670 Customer Service: (800) 877-7195 Web Site: <a href="http://www.vsp.com">www.vsp.com</a>
Union Labor Life Insurance Co.	8403 Colesville Road, 13 <sup>th</sup> Floor Silver Spring, MD 20910 Phone: (202) 682-6768 <a href="http://www.ullico.com">www.ullico.com</a>

## YOUR RIGHTS UNDER ERISA

The Employee Retirement Income Security Act (“ERISA”) was enacted in 1974 to protect the interests of participants and beneficiaries in certain employee benefit plans. As a participant in the Plan, you have certain rights and protections under ERISA. ERISA provides that you, as a participant or beneficiary in each Plan, are entitled to:

- Receive information about your Plan and benefits,
- Continue group health Plan coverage after losing coverage,
- Prudent actions by Plan fiduciaries,
- Enforce your rights,
- Assistance with your questions.

ERISA provides that all participants in an ERISA-subject plan are entitled to:

- Examine, without charge, at the Plan/Fund Administrator’s principal office – and at other specified locations such as worksites and union halls – all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration.
- Obtain copies of documents governing the operation of the Plan and other Plan information by writing to the appropriate Fund Administrator (there may be a reasonable charge for the copies).
- Receive a summary of the Plan’s annual financial report (if any) – the Fund Administrator is required by law to furnish each Plan participant with a copy of this summary annual report.
- Continue health care coverage (either for yourself, or your spouse and/or Dependent children) if there is a loss of coverage under the Plan due to a qualifying event, though you or your Dependents will have to pay for this coverage.

A reduction in, or elimination of, exclusionary periods of coverage for pre-existing conditions that apply under your medical Plans, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes obligations on those responsible for the operation of the Plan. The people who operate the Plan (“fiduciaries”) must do so prudently and in the interest of all Plan participants and beneficiaries.

No one – neither your employer nor any other individual – may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. However, this rule neither guarantees continued employment, nor affects your employer’s right to terminate your employment for other reasons.

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial and you have the right to have the Trustees review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the rights listed above. For instance, if you request a copy of the Plan document or the latest annual report from the Trust Fund Administrator and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to \$110 a day until you receive them, unless they were not sent because of reasons beyond the Administrator’s control.

If your claim for benefits is denied in whole or in part, and you have been through the Plan’s appeals procedure, you may sue in a state or federal court. In addition, if you disagree with the Trust Fund Administrator’s decision concerning the qualified status of a domestic relations order or medical child support order, you may file suit in a federal court after exhausting appeals.

Similarly, if you believe that any Plan fiduciary is misusing Fund 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 win, the court may order the person you sued to pay these legal expenses. If you lose, the court may order you to pay the court costs and legal fees (if, for example, it finds your claim is frivolous).

If you have questions about one of the Plans, you should contact the Trust Fund Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## PRIVACY RIGHTS (UNDER HIPPA)

The health benefit options offered under the Trust Fund use health information about you and your covered Dependents only for the purposes of providing treatment, paying claims, and related functions. A copy of the Fund's Privacy Notice appears below.

To protect the privacy of health information, access to your health information is limited to such purposes. Effective **April 14, 2003**, the health benefit plan options offered under the Trust Fund will comply with the applicable health information privacy requirements in Title II of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the applicable federal regulations issued by the Department of Health and Human Services.

### USE AND DISCLOSURE OF HEALTH INFORMATION

The Trust Fund may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA, for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

**To Make or Obtain Payment.** The Trust Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

The Trust Fund may also disclose health information over the telephone to your spouse, another family member, or a personal representative (such as a union business agent or employer representative), for purposes of making or obtaining information about treatment or claims if you provide your oral authorization to the Trust Fund to speak to this person on your behalf. If you do not wish the Trust Fund to release your health information to your spouse, family member or personal representative without prior *written* authorization, please follow the instructions under the Right to Make Restrictions found in this notice.

**To Conduct Health Care Operations.** The Plan may use or disclose health information for its own operations to facilitate the administration of the Trust Fund and as necessary to provide coverage and services to all Plan participants. For example, the Trust Fund may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

**For Treatment.** The Trust Fund does not provide treatment. However, the Trust Fund may use or disclose your health information to support treatment and the management of your care. For example, the Trust Fund may disclose that you are eligible for benefits to a health care provider who contacts the Trust Fund to verify your eligibility.

**For Treatment Alternatives.** The Trust Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Distribution of Health-Related Benefits and Services.** The Trust Fund may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

**Public Health Risks.** The Trust Fund may disclose medical information about you for public health activities. These activities generally include the following:

- Prevention and control of disease, injury or disability.
- Reporting of births and deaths.
- Reporting child abuse or neglect.
- Reporting reactions to medications or problems with products.
- Notifying people of recalls of products they may be using.
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notifying the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

**For Disclosure to the Plan Sponsor.** The Plan sponsor represents that adequate separation exists between the Plan and Plan Sponsor so that Protected Health Information (“PHI”) will be used only for Plan administration. As a jointly trusteesd multiemployer trust fund which contracts with a third party administrator, the Plan Sponsor has no employees. No person under the control of the Plan Sponsor has access to your PHI. The Trust Fund may disclose your health information to the Plan Sponsor for Plan or Fund administration functions performed by the Plan Sponsor on behalf of the Trust Fund and Plans. Such administration shall include, but is not limited to, the following purposes: appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits, and Plan design. The Trust Fund also may provide summary health information to the Plan Sponsor so that the Plan Sponsor may solicit premium bids from other health plans or modify, amend or terminate the Plan.

As a condition for obtaining PHI from the Trust Fund and other insurers and HMOs participating in the Plan, the Plan Sponsor agrees to:

- Use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.
- Require each of its subcontractors or agents to whom the Plan Sponsor may provide PHI to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
- Bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other employee benefit plans sponsored by the Plan Sponsor.

- Report to the Trust Fund any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your PHI available for purposes of your request for inspection or copying.
- Make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as are allowed under the Privacy Rule.
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.
- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Trust Fund and to the Secretary of the U.S. Department of Health and Human Services (“DHHS”) for the purpose of determining the Plan’s compliance with the Privacy Rule.
- If feasible, return to the Trust Fund or destroy all PHI received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- Use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

**When Legally Required.** The Trust Fund will disclose your health information when it is required to do so by any federal, state or local law.

**Organ and Tissue Donation.** If you are an organ donor, the Trust Fund may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**To Conduct Health Oversight Activities.** Trust The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Trust Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

**In Connection With Judicial and Administrative Proceedings.** As permitted or required by state law, the Trust Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Trust Fund makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purposes.** As permitted or required by state law, the Trust Fund may disclose your health information to a law enforcement official for certain law enforcement

purposes, including, but not limited to, if the Trust Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

**To Coroners, Medical Examiners and Funeral Directors.** The Trust Fund may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Trust Fund may also release your health information to funeral directors as necessary to carry out their duties.

**In the Event of a Serious Threat to Health or Safety.** The Trust Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. Any disclosure would be to someone able to help prevent the threat.

**For Specified Government Functions.** In certain circumstances, federal regulations require the Trust Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

**For Workers' Compensation.** The Trust Fund may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

#### **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than as stated above, the Trust Fund will not disclose your health information without your written authorization. If you authorize the Trust Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

#### **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You have the following rights regarding your health information that the Trust Fund maintains:

**Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust Fund's disclosure of your health information to someone involved in the payment of your care. However, the Trust Fund is not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Officer at the Trust Fund Administration Office.

**Right to Receive Confidential Communications.** You have the right to request that the Trust Fund communicate with you in a certain way if you feel the disclosure of your health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Trust Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Officer at the Trust Fund Administration Office. The Plan will attempt to honor your reasonable requests for confidential communications.

**Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health

information must be made in writing to the Privacy Officer at the Trust Fund Administration Office. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

**Right to Amend Your Health Information.** If you believe that your health information records are inaccurate or incomplete, you may request that the Trust Fund amend the records. That request may be made as long as the Fund maintains the information. A request for an amendment of records must be made in writing to the Privacy Officer at the Trust Fund Administration Office. The Trust Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Trust Fund, if the health information you are requesting to amend is not part of the Trust Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust Fund determines the records containing your health information are accurate and complete.

**Right to an Accounting.** You have the right to request a list of disclosures of your health information made by the Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Officer at the Trust Fund Administration Office. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

**Right to a Paper Copy of this Notice.** You have a right to request and receive a paper copy of this Privacy Notice at any time, even if you have received this Privacy Notice previously or agreed to receive the Privacy Notice electronically. To obtain a paper copy, please contact the Privacy Officer at the Trust Fund Administration Office.

#### **DUTIES OF THE FUND**

The Trust Fund is required by law to maintain the privacy of your health information and to provide to you this Privacy Notice of its duties and privacy practices. The Trust Fund is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Trust Fund reserves the right to change the terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it maintains. If the Trust Fund changes its policies and procedures, the Trust Fund will revise the Privacy Notice and will provide a copy of the revised notice to you within sixty (60) days of the change. You have the right to express complaints to the Trust Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust Fund should be made in writing to the Privacy Officer at the Trust Fund Administration Office. The Trust Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

**CONTACT PERSON**

The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Officer by calling Peter P. Machi, Trust Fund Administrator, at (415) 626-2000.

**EFFECTIVE DATE**

The Fund's privacy policies and procedures became effective April 14, 2003.





