Southern California Painting & Drywall Industries Health & Welfare Trust Fund

Summary Plan Description

Revised September 1, 2017

THIS BOOKLET INCLUDES:

a) Information concerning the benefit structure and operation of the Southern California Painting & Drywall Industries Health & Welfare Trust Fund (the "Plan").

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

c) An explanation of how to file claims and claim appeals.

d) Phone numbers of those who can answer your questions.

THIS BOOKLET ALSO EXPLAINS THE FOLLOWING BENEFITS:

a) The Indemnity PPO Medical Plan for participants who have not selected an HMO plan.

b) Prescription drug benefits for all eligible participants who have not selected the Kaiser plan. For Kaiser Participants, your prescription benefits will be provided directly by Kaiser.

c) Dental Benefits.

d) Vision benefits.

e) Hearing Aid benefits.

f) Death Benefit and Accidental Death and Dismemberment Benefit.

g) Preferred Provider Organization (PPO) information.

If you have selected one of the HMOs offered by the Plan, your medical benefits under that plan will be described in a booklet supplied to you by your HMO.

IMPORTANT TELEPHONE NUMBERS:

Trust Fund Office – English/Spanish	(800) 752-2394 (626) 279-3020
Managed Care - Pre-Admission and Utilization Review (Anthem Blue Cross) – English/Spanish	(800) 274-7767
Optum Rx Program – English/Spanish	(800) 788-7871
Optum Rx Mail Service Drug Program	(800) 562-6223
Kaiser Permanente	(800) 464-4000
Kaiser Permanente – Spanish	(800) 788-0616
Aetna (Multi-Lingual)	(877) 647-3776
DeltaCare USA – English/Spanish	(800) 422-4234
Delta Dental DPO – English/Spanish	(800) 765-6003

Si prefiere revisar este Resumen de la Descripción del Plan en español, por favor comuníquese con la Oficina de Fideicomiso, llamando al (800) 752-2394.

INTRODUCTION AND PREAMBLE

Nature of the Plan and Powers of Trustees to Modify, Reduce and Eliminate Plan Benefits and to Restrict Use of the Plan

This summary has been prepared to provide you with a general description of the structure, operation and other information concerning the Southern California Painting & Drywall Industries Health & Welfare Trust Fund and the benefits provided by the Plan. The Trustees want you to know the purpose for which this Health Fund was designed, how and when you become eligible for coverage, and the benefits you can receive from the Plan. All covered services and benefits are listed. If a benefit or service is not listed, it is not covered.

We urge you to read this booklet carefully so that you may be thoroughly familiar with your Health Plan.

The Southern California Painting & Drywall Industries Health & Welfare Trust Fund is a Multi-Employer Health & Welfare plan which is administered by a Board of Trustees and funded by contributions from employers who are signatory to Collective Bargaining Agreement(s) with Southern California Painters and Allied Trades District Council #36. Half of the Trustees are representatives appointed by the Union and half are appointed by the Employers. The Trustees serve without pay as a service to the industry, the employees, and other beneficiaries participating in the Plan. The Trustees have the sole, full and exclusive discretionary authority to determine all questions regarding eligibility for benefits, to determine the nature and scope of benefits to be provided, to make rules and regulations necessary for the administration of the plan, and to construe the terms and provisions of the trust, and summary plan description. All such decisions, determinations and construction shall be final and binding on all parties. The Trustees have contracted the ministerial duties of administration of the plan's benefits to

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Participating employers contribute into the Fund on either an hourly basis or a pre-determined monthly amount. These contribution rates are adjusted periodically depending on the financial status of the Fund. Contributions in excess of those required to pay benefits and administer the Plan are maintained in various income generating accounts until needed.

The Board of Trustees attempts to develop and maintain an overall program of benefits that can be purchased with the monies being received and that will be of value to all Plan participants and beneficiaries. The Board generally has no power to require employers to pay more money to the Trust to help the Trust maintain benefits at a particular level. Consequently, in order for the Board of Trustees to maintain responsible control over the financial condition of the Trust, the Board must constantly monitor and control the level of benefits being offered. The Board may, at any time, make changes in the type and amount of benefits provided under the Plan and in the eligibility requirements of the Plan**.** This may include, for example, increases or decreases in the number of hours that a participating employee is permitted to accumulate in an hour bank. It also may include the immediate elimination or addition of a type of benefit, increases or decreases in the amount of the deductible payment or in the percentage of charges covered, and, for participants enrolled in the HMO Plan, a change in benefits for that Plan or elimination or

substitution of a current HMO. The Board of Trustees has and retains the right at any time to amend, change or eliminate any benefit under the Plan or the Plan itself. Such decision shall be solely in the discretion of the Trustees.

In order to ensure that all who benefit from the Plan do so appropriately and only as they are entitled, the Board of Trustees reserves the right and authority to impose upon employees and other participants and beneficiaries restrictions with respect to their future rights to receive benefits from the Trust. The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary as, for example, when the Trustees determine that an employee or other participant or beneficiary or health care provider has made any misrepresentation (whether or not intentional) in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of the Plan. The Trustees further reserve the right to deduct from benefits that would normally be paid for later claims the amount of any benefit incorrectly paid or not reimbursed to the Trust when reimbursement is required. Finally, the Trustees reserve the right to seek reimbursement and other damages, together with attorney's fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid, or not reimbursed when reimbursement is required under the Plan.

Also, at this time certain benefits are provided on an insured basis. The Plan contracts for pre-paid medical benefits through certain Health Maintenance Organizations (HMOs). These HMOs currently are Kaiser and Aetna. The Plan also insures on a pre-paid basis the Dental benefits offered through the Trust. These benefits are provided by Delta Dental, Inc.

Prescription benefits are administered by Optum Rx, or for Kaiser members, provided on a pre-paid basis directly by Kaiser. Utilization Review and Pre-Admission Review services are provided by Anthem Blue Cross. Large claim indemnity stop-loss insurance is purchased from Swiss Reinsurance Corporation. This insurance pays certain medical claims that are in excess of the Plan’s self-insured Indemnity PPO Plan claim retention.

The Health Fund contracts with Anthem Blue Cross of California for its Prudent Buyer Network which includes hospitals, physicians, laboratories, x-ray facilities and ancillary services. If you use a Prudent Buyer Provider, you will be afforded quality health care, save money, and the Health Trust will save money. For help in locating Prudent Buyer Providers, consult your Blue Cross Prudent Buyer Directory, go to the Anthem Blue Cross website www.anthem.com or contact the Trust Fund Office at (800) 752-2394.

Be advised that even if a certain provider is included in the directory, that provider may no longer be contracted with the Anthem Blue Cross PPO Network, or the particular services of that provider may not be covered by the Trust Fund’s plan of benefits. It is up to each Plan participant to call their providers to verify they are currently a member of the PPO network before utilizing their services, and to check with the Trust Fund Office to confirm what benefits are covered or excluded by the Plan, otherwise it may cost you more in out-of-pocket expenses.

INDEMNITY PPO PLAN AND AETNA LEVEL C - ONLY
NOTICE OF GRANDFATHERED STATUS
OF THE HEALTH PLAN FOR ACTIVE EMPLOYEES AND DEPENDENTS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at (800) 752-2394. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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SOUTHERN CALIFORNIA PAINTING & DRYWALL INDUSTRIES
HEALTH & WELFARE TRUST FUND SUMMARY PLAN DESCRIPTION

SECTION 1
PREFERRED PROVIDER ORGANIZATION (PPO) GUIDELINES

The Anthem Blue Cross PPO Network gives you access to a complete network of PPO Providers of health care at reasonable costs. This network includes many of the major hospitals throughout California. It also includes over 30,000 physicians, laboratories, x-ray facilities and other service providers.

The PPO network is a voluntary, optional program for you and your dependents. If you use a PPO network provider, you will save money. Your benefit will be increased to a higher percentage of the contracted rates rather than a percentage of "usual, customary and reasonable" fees ("UCR"). Contracted rates are lower than the "usual, customary and reasonable" fees (See example on the following page).

The Plan will pay up to allowed percentages of Contract Rates for using PPO Providers as specified in the following Sections depending on whether coverage is provided through Plan "A", "B" or "C" (See Section 5 entitled "Benefits").

The network directory describes how the system operates and lists the participating providers in Southern California. Whenever you are scheduled for a procedure that includes more than one provider (i.e., anesthesiologist, specialist, lab work) be sure that each provider is a PPO provider. Just because the referring doctor is in the PPO Network does not mean the referrals are also in the Network. If you do not have a network directory call the Trust Fund Office at (800) 752-2394 or (626) 279-3020. Also offered is the Anthem Blue Cross website www.anthem.com and a PPO Info line (800) 752-2394 to give instant access to provider updates and any help you need to best use the network. The toll-free number will be staffed Monday - Friday from 8 a.m. to 5 p.m. This number is for the exclusive use of the participants, and their dependents, covered by the Southern California Painting & Drywall Industries Health & Welfare Trust Fund.

The advantages of using a PPO Medical Network provider:

- You will be afforded quality health care.
- You will save money through lower medical service charges and a higher percentage paid by the Plan on those charges.
- The Plan will save money.
- The provider will file health claims for you.

PPO vs. Non-PPO Example

Using an Anthem Blue Cross PPO Provider can save you a great deal of money. The following example shows how the Trust would process a $1,000 bill for medically necessary services.

The amount you would pay to the PPO Provider ($50.00) is dramatically lower than what you would pay to the non-PPO Provider ($440.00). Your cost will vary depending on which Plan level you are eligible for.

Plan A Example

PPO Provider		***Non-PPO Provider***
$1,000	*Billed Charges*	*$1,000*
$500	*PPO Rate – UCR Rate*	*$800*
$500	*PPO Discount*	*N/A*
$500	*Allowed Amount*	*$800*
90%	*Plan Pays (%)*	*70%*
$450	*Plan Pays ($)*	*$560*
$50	*Your Co-Payment ($)*	*$240*
$0	*The Amount you will be balance billed for using a non-PPO Provider*	*$200*
$50	***YOUR COST***	***$440***

ABOUT THE NETWORK

Should I Choose a Primary Care Physician?

The Anthem Blue Cross PPO Network has both primary care physicians and specialists. The Network primary care physicians are family practitioners, internists, obstetricians/gynecologists and pediatricians who have agreed to accept discounted rates and refer to other Network providers, when possible.

It is to your benefit to establish a close relationship with a primary care physician so that he or she can become familiar with your health care needs and serve as your personal advisor on health care matters. It makes good medical sense to select and use a single primary care physician for most of your healthcare needs. Coordination of your medical care through one physician avoids duplication and conflicting treatments. Whenever you feel it is necessary to change physicians, you may do so. You and your enrolled dependents may each select a different primary care physician if you so choose.

What About Referrals to Specialists?

Your primary care physician will refer you to a specialist if necessary. Be sure to remind your doctor to refer you to an Anthem Blue Cross participating provider (for example, specialist, laboratory, radiology facility). You may also go directly to an Anthem Blue Cross specialist and still take advantage of the network contract rates.

What Are My Financial Responsibilities?

One of the advantages of using the Anthem Blue Cross providers is that they have agreed to collect from Participants who have elected to participate in the Indemnity PPO Plan only deductibles, coinsurance and non-covered services. Once you authorize assignment of benefits to the provider, you do not have to pay

the full bill up front. You pay only the amounts you owe under the plan after you receive an Explanation of Benefits from the Trust Fund Office.

By using an Anthem Blue Cross provider you are reducing your coinsurance payment for covered services to a percentage of the network contract rate, instead of a percentage of "usual, customary, and reasonable" charges. Another advantage of using network providers is that you do not pay any charges above the network contract rates.

For providers who are not part of the Anthem Blue Cross network, you are responsible to pay any charges above "usual, customary, and reasonable" charges, plus all deductibles and co-insurance payments and any non-covered services.

Coordination of Benefits (COB)

The Anthem Blue Cross contract rates apply if your Southern California Painting & Drywall Health & Welfare Trust Fund is either your primary or secondary coverage. This plan would be secondary, for example, for a spouse who has primary coverage under another health plan. If this plan is secondary coverage, be sure to attach the "Explanation of Benefits" from the primary plan to any claim submitted to this Plan.

Quality Health Care at an Affordable Cost

One of the best features of the Anthem Blue Cross Network is that you still have freedom to choose any provider for services, but you save when you choose a network provider. This network enables you to be an active participant in making health care more affordable for you and preserving the plan for your future.

HEALTH MAINTENANCE ORGANIZATION (HMO) OPTION

HMO medical programs are available under this Plan through Aetna and Kaiser. Once per year, HMO enrollment is available during an Annual Enrollment Period. You may also enroll in an HMO when you first become eligible for medical benefits under the Plan. If, upon initially becoming eligible for benefits under the Plan, you do not complete and return an HMO enrollment form before the enrollment deadline, you will automatically be enrolled in the Indemnity PPO Plan Level C. **Contact the Trust Fund Office if you have questions about the benefits offered through each plan. A brief comparison of the benefits is provided beginning at page 4.**

Comparison of Medical Benefit Plan Charts

Indemnity PPO Plan

Kaiser Permanente (HMO) Plan

Aetna (HMO) Plan

Plan Level A

Plan Level B

Plan Level C

Comparison of Benefits
Plan Level A

Comparison of Benefits
Plan Level B

Comparison of Benefits
Plan Level C

Comparison of Benefits

Plan Level A

Plan Options Offered to Eligible Members in Plan Level A	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
Annual Calendar Year Maximum	None		None	None
Calendar Year Deductible Deductible must be met before reimbursement of expenses is made by Plan	$250/Individual $750/Family		None	None
Annual Copay Limit Individual	$4,000/person		$1,500/Individual $3,000/Family	$1,000/Individual (1) $3,000/Family
Type of Organization	PPO Provider	Non-PPO Provider (Benefits are reduced when services are received by providers and at facilities outside of Anthem Blue Cross of California)	Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed - Payable by Plan	Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed - Payable by Plan
Services	All services are subject to the deductible. Percentages payable by Plan are shown below. If pre-admission review requirements are not followed, the Plan will reduce the amount it pays by 10 percentage points.		The Plan does not cover all health care expenses and includes exclusions and limitations. (Refer to Kaiser Permanente's *Evidence of Coverage*)	The Plan does not cover all health care expenses and includes exclusions and limitations. (Refer to Aetna's *Evidence of Coverage*)
Hospital Inpatient Care	Room and board, surgery, anesthesia, X-rays, lab tests and medications that are medically necessary.		100% per admission during a member's inpatient stay	100% per admission during a member's inpatient stay
	90% of PPO Rate	70% OF UCR		
Hospital Outpatient Care	90% of PPO Rate	70% OF UCR	$25 copay per visit	100%
Hospice Care	90% of PPO Rate	70% OF UCR	100%	100%

(1) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Plans Offered Plan Level A	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Outpatient Care	Primary and specialty care visits for internal medicine, family practice, maternity care visits, pediatrics and gynecology visits include routine and urgent care appointments		Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Aetna's *Evidence of Coverage (EOC)*
	90% of PPO Rate	70% of UCR	$25 copay	$25 copay
Hearing exam	90% of PPO Rate	70% of UCR	$25 copay	$25 copay
Hearing Aid Benefits (for Indemnity and HMO Plans)	Hearing Aids Aid replacement Exams* Molds Mold replacement	Up to $1,500 per Aid Every 4 years, if needed Up to $75 per year Up to $50 per Mold Twice per year if needed		* Applies to Indemnity Plan eligible only; HMO eligible must receive hearing exams through their HMOs
Outpatient surgery	90% of PPO Rate	70% of UCR	$25 copay	100%
Routine Care	The Plan allows routine physical examination, gynecological visits every 12 months		Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Aetna's *Evidence of Coverage (EOC)*
	90% of PPO Rate	70% of UCR	$25 copay	$25 copay
Immunizations Well-Baby Care	**Immunization** – as medically necessary **Well-Baby Care** – as medically necessary		No Charge	No Charge
Immunizations - for dependent children up to age 26	90% of PPO Rate	70% of UCR	100%	100%
Allergy injection visits	Mandatory Pre-authorization			
	90% of PPO Rate	70% of UCR	$25 copay	$25 office visit copay

Plans Offered Plan Level A	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Physical Therapy, Chiropractic Care and Acupuncture treatments	90% of PPO Rate — This is a combined benefit. Maximum of 25 visits per	70% of UCR — This is a combined benefit. Maximum of 25 visits per	Chiropractic and Acupuncture treatments are not covered	Chiropractic and Acupuncture treatments are not covered
	90% of PPO Rate	70% of UCR	$25 copay for physical therapy	$25 copay for physical therapy
Emergency Services	90% of PPO Rate	70% of UCR	$50 copay/	$50 copay/ waived if admitted
Additional Benefits				
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care 60 Day Maximum per admission	90% of PPO Rate with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	70% of UCR with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	100% — up to 100 visits per calendar year	100%
Ambulance Services	90% of PPO Rate	70% of UCR	100%	100%
Coordination of Benefits	**Call the Trust Fund Office for information as to how this Plan may pay if you are enrolled in other Plans.**		Included —Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Aetna's *Evidence of Coverage (EOC)*
Other Services MRI/SCAN	90% of PPO Rate	70% of UCR	100%	100%
Outpatient X-Ray and Lab	90% of PPO Rate	70% of UCR	100%	100%

Plans Offered Plan Level A	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Durable Medical Equipment	All rental equipment and all purchases of medical supply or equipment in excess of $1,000 must be approved in advanced by the Trust Fund Office. **Call 1.800.752.2394**		Covered durable medical equipment in accord with Kaiser Permanente's formulary	Covered durable medical equipment in accord with Aetna's policy
	90% of PPO Rate	70% of UCR	100%	100%
Mental Health Services Inpatient	90% of PPO Rate	70% of UCR	100%	100%
Outpatient Psychotherapy	90% of PPO Rate	70% of UCR	$25 copay per visit $12 copay per group therapy visit	$25 copay
Substance Abuse Inpatient (Detox Only)	90% of PPO Rate	70% of UCR	100%	100%
Outpatient	90% of PPO Rate	70% of UCR	$25 copay per individual $5 copay per group	$25 copay
Dental Benefits	Plan Level A — see page 25		Plan Level A — see page 25	Plan Level A — see page 25
Vision Benefits	Plan Level A — see page 26		$25/eye exam only (See Schedule of Vision Benefits)	$25 copayment, eye exam only (See Schedule of Vision Benefits)

Comparison of Benefits

Plan Level B

Plan Options Offered to Eligible Members in Plan Level B	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
Annual Calendar Year Maximum	None		None	None
Calendar Year Deductible Deductible must be met before reimbursement of expenses is made by Plan	$250/Individual $750/Family		None	None
Annual Copay Limit Individual	$4,000/person		$1,500/Individual $3,000/Family	$1,000/Individual (1) $3,000/Family
Type of Organization	PPO Provider	Non-PPO Provider (Benefits are reduced when services are received by providers and at facilities outside of the Prudent Buyer Plan network)	Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed - Payable by Plan	Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed - Payable by Plan
Services	All services are subject to the deductible. Percentages payable by Plan are shown below. If pre-admission review requirements are not followed, the Plan will reduce the amount it pays by 10 percentage points.		The Plan does not cover all health care expenses and includes exclusions and limitations. (Refer to Kaiser Permanente's *Evidence of Coverage*)	The Plan does not cover all health care expenses and includes exclusions and limitations. (Refer to Kaiser Permanente's *Evidence of Coverage*)
Hospital Inpatient Care	Room and board, surgery, anesthesia, X-rays, lab tests and medications that are medically necessary		100% per admission during a member's inpatient stay	100% per admission during a member's inpatient stay
	80% of PPO Rate	60% OF UCR		
Hospital Outpatient Care	80% of PPO Rate	60% OF UCR	$25 copay per visit	100%
Hospice Care	80% of PPO Rate	70% OF UCR	100%	100%

(1) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Plans Offered Plan Level B	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Outpatient Care	Primary and specialty care visits for internal medicine, family practice, maternity care visits, pediatrics and gynecology visits include routine and urgent care appointments		Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Aetna's *Evidence of Coverage (EOC)*
	80% of PPO Rate	60% of UCR	$25 copay	$25 copay
Hearing exam	80% of PPO Rate	60% of UCR	$25 copay	$25 copay
Hearing Aid Benefits (for Indemnity and HMO Plans	Hearing Aids Aid replacement Exams* Molds Mold replacement	Up to $1,500 per Aid Every 4 years, if needed Up to $75 per year Up to $50 per Mold Twice per year if needed		* Applies to Indemnity Plan eligible only; HMO eligible must receive hearing exams through their HMOs
Outpatient surgery	80% of PPO Rate	60% of UCR	$25 copay	100%
Routine Care	The Plan allows routine physical examination, gynecological visits every 12 months		Refer to Kaiser Permanente's Evidence of Coverage (EOC)	Refer to Aetna's Evidence of Coverage (EOC)
	80% of PPO Rate	60% of UCR	$25 copay	$25 copay
Well-Baby Care and Immunizations Well-Baby Care	**Immunization** – as medically necessary **Well-Baby Care** – as medically necessary		No Charge	No Charge
Immunizations - for dependent children up to age 26	80% of PPO Rate	60% of UCR	100%	100%
Allergy injection visits	Mandatory Pre-authorization			
	80% of PPO Rate	60% of UCR	$25 copay	$25 copay

Plans Offered Plan Level B	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Physical Therapy, Chiropractic Care and Acupuncture treatments	80% of PPO Rate This is a combined benefit. Maximum of 25 visits per calendar year.	60% of UCR Rate This is a combined benefit. Maximum of 25 visits per calendar year.	Chiropractic and Acupuncture treatments are not covered	Chiropractic and Acupuncture treatments are not covered
	80% of PPO Rate	60% of UCR	$25 copay for physical therapy	$25 copay for physical therapy
Emergency Services	80% of PPO Rate	60% of UCR	$50 copay/ waived if admitted	$50 copay/ waived if admitted
Additional Benefits				
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care 60 Day Maximum per admission	80% of PPO Rate with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	60% of UCR with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	100%— up to 100 visits per calendar year	100%
Ambulance Services	80% of PPO Rate	60% of UCR	100%	100%
Coordination of Benefits	**Call the Trust Fund Office for information as to how this Plan may pay if you are enrolled in other Plans.**		Included — Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Aetna's *Evidence of Coverage (EOC)*
Other Services MRI/SCAN	80% of PPO Rate	60% of UCR	100%	100%
Outpatient X-Ray and Lab	80% of PPO Rate	60% of UCR	100%	100%

Plans Offered Plan Level B	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Durable Medical Equipment	All rental equipment and all purchases of medical supply or equipment in excess of $1,000 must be approved in advanced by the Trust Fund Office. **Call 1.800.752.2394**		Covered durable medical equipment in accord with Kaiser Permanente's formulary	Covered durable medical equipment in accord with Aetna's policy
	90% of PPO Rate	70% of UCR	100%	100%
Mental Health Services Inpatient	80% of PPO Rate	60% of UCR	100%	100%
Outpatient Psychotherapy	80% of PPO Rate	60% of UCR	$25 copay per individual $12 copay per group therapy visit	$25 copay
Substance Abuse Inpatient (Detox Only)	80% of PPO Rate	60% of UCR	100%	100%
Outpatient	80% of PPO Rate	60% of UCR	$25 copay per individual $5 copay per group	$25 copay
Dental Benefits	Plan Level B — see page 31		Plan Level B — see page 31	Plan Level B — see page 31
Vision Benefits	Plan Level B — see page 32		$25 copay/eye exam only (See Schedule of Vision Benefits)	$25 copay/eye exam only (See Schedule of Vision Benefits)

Comparison of Benefits

Plan Level C

Plan Options Offered to Eligible Members in Plan Level C	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
Annual Calendar Year Maximum	None		None	None
Calendar Year Deductible Deductible must be met before reimbursement is made	$250/Individual $750/Family		None	None
Annual Copay Limit Individual	$4,000/person		$1,500/Individual $3,000/Family	$1,000/Individual (1) $3,000/Family
Type of Organization	PPO Provider	Non-PPO Provider (Benefits are reduced when services are received by providers and at facilities outside of the Prudent Buyer Plan network)	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Services	All services are subject to the deductible. Percentages payable by Plan are shown below. If pre-admission review requirements are not followed, the Plan will reduce the amount it pays by 10 percentage points.		Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed Payable by Plan	Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed Payable by Plan
Hospital Inpatient Care	Room and board, surgery, anesthesia, X-rays, lab tests and medications that are medically necessary			
	70% of PPO Rate	50% OF UCR	100% per admission during a member's inpatient stay	100% per admission during a member's inpatient stay
Hospital Outpatient Care	70% of PPO Rate	50% OF UCR	$25 copay per visit	100%
Hospice Care	70% of PPO Rate	50% OF UCR	100%	100%

(1) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Plans Offered Plan Level C	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Outpatient Care	Primary and specialty care visits for internal medicine, family practice, maternity care visits, pediatrics and gynecology visits include routine and urgent care appointments		Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Aetna's *Evidence of Coverage (EOC)*
	70% of PPO Rate	50% of UCR	$25 copay	$25 copay
Hearing exam	70% of PPO Rate	50% of UCR	$25 copay	$25 copay
Hearing Aid Benefits (for Indemnity and HMO Plans)	Hearing Aids Aid replacement Exams* Molds Mold replacement	Up to $1,500 per Aid Every 4 years, if needed Up to $75 per year Up to $50 per Mold Twice per year if needed		* Applies to Indemnity Plan eligible only; HMO eligible must receive hearing exams through their HMOs
Outpatient surgery	70% of PPO Rate	50% of UCR	$25 copay	Covered 100%
Routine Care	The Plan allows routine physical examination, gynecological visits every 12 months		Refer to Kaiser Permanente's Evidence of Coverage (EOC)	Refer to Aetna's Evidence of Coverage (EOC)
	70% of PPO Rate	50% of UCR	$25 copay	$25 copay
Well-Baby Care and Immunizations Well-Baby Care	**Immunization** — as medically necessary **Well-Baby Care** — as medically necessary		No Charge	No Charge
Immunizations - for dependent children up to age 26	70% of PPO Rate	50% of UCR	100%	100%
Allergy injection visits	Mandatory Pre-authorization			
	70% of PPO Rate	50% of UCR	$25 copay	$25 copay

Plans Offered Plan Level C	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO	Health Maintenance Organization (HMO
Physical Therapy, Chiropractic Care and Acupuncture treatments	This is a combined benefit. Maximum of 25 visits per calendar year..	This is a combined benefit. Maximum of 25 visits per calendar year..	Chiropractic and Acupuncture treatments are not covered	Chiropractic and Acupuncture treatments are not covered
	70% of PPO Rate	50% of UCR	$25 copay for physical therapy	$25 copay for physical therapy
Emergency Services	70% of PPO Rate	50% of UCR	$50 copay/ waived if admitted	$50 copay/ waived if admitted
Additional Benefits				
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care 60 Day Maximum per admission	70% of PPO Rate with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	50% of UCR with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	100%	100%
Ambulance Services	70% of PPO Rate	50% of UCR	100%	100%
Coordination of Benefits	**Call the Trust Fund Office for information**		Included —Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Aetna's *Evidence of Coverage (EOC)*
Other Services MRI/SCAN	70% of PPO Rate	50% of UCR	100%	100%
Outpatient X-Ray and Lab	70% of PPO Rate	50% of UCR	100%	100%

Plans Offered Plan Level C	Indemnity Plan		Kaiser Permanente Plan	Aetna Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO	Health Maintenance Organization (HMO
Durable Medical Equipment	All rental equipment and all purchases of medical supply or equipment in excess of $1,000 must be approved in advanced by the Trust Fund Office. **Call 1.800.752.2394**		Covered durable medical equipment in accord with Kaiser Permanente's formulary	Covered durable medical equipment in accord with Aetna's policy
	70% of PPO Rate	50% of UCR	100%	100%
Mental Health Services Inpatient	70% of PPO Rate	50% of UCR	100%	100%
Outpatient Psychotherapy	70% of PPO Rate	50% of UCR	$25 copay per visit $12 copay per group therapy visit	$25 copay
Substance Abuse Inpatient (Detox Only)	70% of PPO Rate	50% of UCR	100%	100%
Outpatient	70% of PPO Rate	50% of UCR	$25 copay per individual $5 copay per group	$25 copay
Dental Benefits	Not covered		Not covered	Not covered
Vision Benefits	Not covered		$25 copay /eye exam only Materials not covered	$25 copay /eye exam only Materials not covered

SECTION 2
PRE-ADMISSION AND UTILIZATION REVIEW

When an inpatient admission is necessary to any hospital, the Plan's Utilization Review Program must be used to assure that you receive both the appropriate service and the highest level of reimbursement available from the Plan.

Pre-admission Review for Scheduled Admissions

It is important to confirm that planned services are appropriate to your needs. A Pre-Admission Review should be performed before you enter any hospital for any non-emergency or non-urgent admission. The review confirms that the admission and any planned procedures are medically necessary. Hospital Pre-Admission Review may include review by a consulting physician for a second opinion at no cost to you.

If you are scheduled for a hospital stay, your physician should call Managed Care at (800) 274-7767 for pre-admission review. Please remind your physician to do so. You should also show your health plan card to the admissions personnel at the facility when you are admitted to be sure the pre-admission review has been completed. If not completed by your physician, have the facility complete the process for you.

Outpatient Services

Utilization Review may suggest that you use outpatient services. Many medical and surgical services can be safely provided on an outpatient basis. This will allow you to recover at home, and may save you and the plan money.

Emergency Admission Review

If you are admitted to a hospital in an emergency there is no immediate requirement for pre-admission review. However, your physician or the admissions personnel must call Managed Care at (800) 274-7767 within 24 hours of your admission to initiate an emergency admission review.

Continued Hospital Stay Review

Hospital days that are not medically necessary are expensive and should be avoided. The review organization will conduct periodic reviews during your hospital stay to determine whether continued hospitalization is appropriate.

These review procedures are important to you and to the health plan. **Failure to obtain a Pre-admission review or emergency admission review may result in a denial of benefits or benefit reduction**.

SECTION 3
SUMMARY OF MAJOR MEDICAL EXPENSE BENEFITS

The Preferred Provider Network (PPO) is a voluntary, optional program to you. If you use a PPO Network provider, your benefit will be 90% of the contract rates if in Plan Level A, 80% if in Plan Level B, and 70% if in Plan Level C rather than the 70% / 60% / 50% of Usual, Customary & Reasonable (UCR) charges. You must also use Pre-Admission Review Procedures, when required, to receive the full benefit. For information on the Preferred Providers in your area, you may contact the Trust Fund Office at (800) 752-2394, or search PPO providers at www.anthem.com.

	PLAN LEVEL A	PLAN LEVEL B	PLAN LEVEL C
Lifetime Maximum Per Person	**No Maximum**	**No Maximum**	**No Maximum**
Calendar Year Deductible	**$250 Per Individual $750 Per Family**	**$250 Per Individual $750 Per Family**	**$250 Per Individual $750 Per Family**
Annual Out of Pocket Maximum	**$4,000 Per Person**	**$4,000 Per Person**	**$4,000 Per Person**
	PLAN LEVEL A	**PLAN LEVEL B**	**PLAN LEVEL C**
TYPE OF SERVICE	**PPO / Non-PPO**	**PPO / Non-PPO**	**PPO / Non-PPO**
Hospital Inpatient Care	**90% / 70%**	**80% / 60%**	**70% / 50%**
Hospital Outpatient Care	**90% / 70%**	**80% / 60%**	**70% / 50%**
Outpatient Care	**90% / 70%**	**80% / 60%**	**70% / 50%**
Office Visit	**90% / 70%**	**80% / 60%**	**70% / 50%**

Levels are determined based on hours worked. Please refer to the Section entitled "Plan Selection Level" on page 46.

Reductions in Coverage

You may decrease your level of coverage during the year. However, you can only select a higher Plan Level after you have been enrolled in the initial or current Plan level for twelve (12) consecutive months. To do this, you must provide the Trust Fund Office with notice in writing at least 30 days before the first day of the month for which the change is to become effective.

SECTION 4
MAJOR MEDICAL BENEFIT INFORMATION

NOTE: If you have elected an HMO Plan, your Major Medical Expense benefits are provided by your HMO directly and your benefits are described in a separate booklet provided by that HMO.

PPO: Hospital services require Pre-Admission Review prior to a scheduled admission or within 24 hours or as soon as practical after an emergency or admission. Please contact Managed Care at (800) 274-7767.

COVERED EXPENSES

In addition, to the services listed in Section 5, the following services and supplies are Covered Expenses:

Hospital Outpatient

The charges of a Hospital for medical services and supplies furnished on an outpatient basis.

Outpatient Surgery

Charges for medical services and supplies furnished on an outpatient basis.

The maximum covered expense for an assistant surgeon whether the procedure is performed on an inpatient or out-patient basis and only when medically required is limited to 20% of the Usual, Customary and Reasonable (UCR) charge for the surgery or as provided for in the applicable Preferred Provider agreement.

Physician

Charges for diagnosis and treatment of injury or illness.

Private Duty Nursing

Note: In order to receive maximum benefits, please call Managed Care Utilization Review Department at (800) 274-7767 prior to scheduling private duty nursing.

Private duty nursing by a registered graduate nurse (R.N.), registered or licensed practical nurse (L.P.N.); or licensed vocational nurse (L.V.N.), if prescribed by a physician. This does not include a nurse who is related to a covered person by blood, marriage or adoption or is normally a member of a covered person's household.

Medical Supplies and Equipment

1) Initial rental or purchase, at this Plan's option, of Durable Medical Equipment used for therapeutic purposes. Replacement of these items is not covered.

2) The initial external breast prosthesis following mastectomy.

3) Initial braces, crutches and prostheses needed because of injury that occurs while covered, or sickness that begins while covered. Replacement of these items is not covered.

4) Colostomy bags and related supplies.

5) Catheters.

6) Syringes and needles for insulin and allergy injections.

7) Prescription, custom-fitted support stockings;

   a) initial purchase; and

   b) one replacement pair per year.

8) Orthotics: The Trust will cover orthotic shoe inserts under the following circumstances, subject to medical necessity and Usual & Customary protocols and charges:

   a) Custom shoe inserts as prescribed by a physician or podiatrist for the treatment of diabetes-related foot conditions. Replacement inserts will also be covered up to one (1) set per year.

   b) Therapeutic Shoes – Custom molded footwear made to accept the diabetes-related shoe inserts will be covered no more than one pair every two (2) years.

   c) Rigid custom molded shoe inserts as prescribed by a physician or podiatrist to correct physical deformities or infirmities due to disease or injury will be covered no more than one pair every three (3) years.

   d) Over-the-counter shoe inserts are excluded, as are arch supports, orthopedic shoes, and all other footwear and inserts not meeting the above criteria.

   e) Orthotics are not covered if prescribed for fallen arches or flat feet.

All purchases of Medical Supplies or Equipment in excess of $1,000 must be approved in advance by Managed Care Utilization Review Department. All rental equipment must be pre-authorized as well, regardless of the cost for rental. Call (800) 274-7767 for additional information.

Sterilization/Reversal of Sterilization/Infertility

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

Organ Transplant

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

In addition, the donor of an organ for transplant to a covered recipient will be provided inpatient benefits for a maximum of 10 days, up to a maximum of $10,000 toward all donor medical expenses except when donor benefits are available through other group coverage or government funding of any kind.

Note: In order to receive maximum benefits, please call Managed Care Utilization Review Department at (800) 274-7767 prior to a scheduled hospital admission or within 24 hours of an emergency hospital admission or prior to any surgery.

MEDICARE PROVISION

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

SECTION 5
BENEFITS

A. SCHEDULE OF COVERAGE - INDEMNITY PPO PLAN "A"

The following is a description of the medical benefits, including Dental, Orthodontia, Vision, Hearing Aid that apply to eligible participants enrolled in Indemnity PPO Plan A. Hearing Aid and Vision Materials are provided under the Indemnity PPO Plan, but if you are in an HMO, your vision and hearing examinations must be obtained through the HMO.

Major Medical Expense Benefits

1. Lifetime Maximums:

   There is no lifetime maximum.

2. Deductible:

   $250 per Calendar Year per Individual and $750 per Calendar Year per Family.

3. Annual Out of Pocket Maximum:

   $4,000 per person - 100% of eligible expenses will be paid after you have had eligible out of pocket expenses of $4,000 in a calendar year. All remaining eligible expenses for that year will be reimbursed at up to 100% of UCR charges or 100% of the PPO rate when using PPO Providers.

4. Level of Reimbursement:

   a. ***Using PPO Provider and Pre-Admission Review Procedures:***
   90% of the PPO Rate is paid when using PPO Providers and Hospitals.

   The PPO Provider Network is a voluntary, optional program to you. If you use a PPO Network provider, your benefit will be increased to 90% of the PPO contract rates rather than a lower percentage paid on Usual, Customary & Reasonable (UCR) charges. **You must use Pre-Admission Review Procedures, when required, to receive benefits paid at 90% of the PPO contract rates.** For Information on the Preferred Providers in your area you may contact the Trust Fund Office at (800) 752-2394 or search for PPO providers at www.anthem.com.

   b) ***Using Non-PPO Provider and Pre-Admission Review Procedures:***
   70% of the UCR (Usual, Customary and Reasonable) rate is paid when using a non-PPO Provider as long as Pre-Admission Review procedures were followed when required.

   Non-PPO Providers means hospitals, physicians, chiropractors, other health care professionals, and providers of ancillary services who do not participate in the PPO network through the

Anthem Blue Cross Prudent Buyer plan (Non-PPO providers receive a lower level of reimbursement. Please see below.)

Non-PPO Hospital includes in-patient, out-patient and emergency room services provided by a non-PPO Hospital.

Pre-admission review rules must be followed when required.

Failure to obtain a Pre-Admission Review or emergency admission review may result in a denial of benefits or benefit reduction.

5. Ground Ambulance Service:

Licensed ground ambulance service to transport a covered person to the nearest facility qualified to treat the sickness or injury. While the regular percentage co-payment normally applies to Ground Ambulance Service, 100% of UCR charges for ground ambulance cost will be paid to transfer a patient from a non-Preferred Provider Hospital to a Preferred Provider Hospital which is within 50 miles of the non-Preferred Provider Hospital when the transfer is approved by the attending physician and by the Managed Care Department.

6. Second Surgical Opinion:

100% of the Usual, Customary & Reasonable (UCR) charges for a second opinion for surgery when the second opinion is arranged by the Managed Care Department (800) 274-7767.

7. Hospital Room & Board:

a. ***Using PPO Provider and Pre-Admission Review Procedures:***
90% of Anthem Blue Cross PPO contract rate if a PPO hospital is used and Pre-Admission procedures are followed.

b. ***Using non-PPO Provider and Pre-Admission Review Procedures:***
70% of UCR if non-PPO Hospital is used and Pre-Admission Review procedures are followed.

Failure to obtain a Pre-Admissions Review for emergency admission review may result in a denial of benefits or benefit reduction.

8. Convalescent / Home Health Care / Skilled Nursing Facility / Hospital Daily Rate *This is a combined benefit*:

Confinement must begin within 14 days after the end of confinement of at least 3 days in a hospital and must be for the same sickness or injury causing the preceding hospitalization. Confinement must not be for custodial care. Covered:

a. $100 per day to a maximum of 60 days per admission. (The $100 maximum does not apply for convalescent services rendered at a skilled nursing facility).

b. Services and supplies which are furnished for medical care therein.

9. Hospice Care –For patients with terminal prognosis up to 6 months maximum.

10. California End of Life Option Act – For patients 18 years of age or older, mentally competent and diagnosed with a terminal illness that will, within reasonable medical judgment, lead to death within six (6) months.

11. Outpatient Surgical Facility -Non-PPO Rates by County

County (where facility located):	**Maximum Rate Per Surgery:**
Los Angeles/Orange/San Diego:	$2,900 (Plan pays 80%)
Riverside/San Bernardino	$2,450 (Plan pays 80%)
San Luis Obispo/Santa Barbara/Kern:	$1,910 (Plan pays 80%)
Ventura:	$2,340 (Plan pays 80%)

12. Outpatient Psychotherapy and Psychometric testing

a. Using PPO Provider and Pre-Admission Review Procedures:
90% of the PPO Rate is paid when using PPO Providers.

b. Using Non-PPO Provider and Pre-Admission Review Procedures:
70% of the UCR (Usual, Customary and Reasonable) rate is paid when using a non-PPO Provider.

13. Inpatient Mental Health Benefits

a. Using PPO Provider and Pre-Admission Review Procedures:
90% of Anthem Blue Cross PPO contract rate if a PPO hospital or mental health/substance abuse facility is used and Pre-Admission procedures are followed.

b. Using non-PPO Provider and Pre-Admission Review Procedures:
70% of UCR if non-PPO Hospital or non-PPO Mental Health/Substance Abuse Facility is used and Pre-Admission Review procedures are followed.

Failure to obtain a Pre-Admission Review or emergency admission review may result in a denial of benefits or benefit reduction.

14. Chiropractic Care, Physical Therapy and Acupuncture

(The Physical Therapy, Acupuncture and Chiropractic, benefits are combined for purposes of applying the maximum number of services, which is 25 visits per calendar year)

a. Using PPO Provider:
90% of the PPO rate when PPO Chiropractor, Physical Therapist (PT) or Acupuncturist is used.

b. Using Non-PPO Provider:
70% of Usual, Customary & Reasonable charges when non-PPO Chiropractor, Physical Therapist (PT) or Acupuncturist is used.

The Plan shall pay no more than $100 per participant for medically necessary x-rays for chiropractic in a calendar year.

15. Routine Physical and Gynecological Exam Services

The Plan allows one routine physical examination and gynecological visits every 12 months.

16. Smoking Cessation

The smoking cessation benefit will allow you to receive smoking cessation products through the Trust's prescription program administered by Optum Rx. OTC (over the counter) nicotine replacement products require a physician's prescription. Nicotine replacement therapy is limited to two (2) courses of treatment per lifetime.

Covered products will include both prescription and over-the-counter nicotine replacement products. Covered purchases will be subject to the current prescription co-pay of $10 for a 30-day supply.

First Treatment
In order to be eligible to receive or be reimbursed for the smoking cessation products for your initial course of treatment, you must provide the pharmacist or Trust Fund Office with a physician's prescription.

Second Treatment
In order to be eligible to receive or be reimbursed for the smoking cessation products for your second course of treatment, you must provide the pharmacist or Trust Fund Office with a physician's prescription. You must also show proof of purchase of a smoking cessation course such as "Smokenders".

The Trust will reimburse up to two (2) courses of treatment per lifetime upon your submission of your proof-of-purchase of a smoking cessation course. **Although the first course of treatment is not mandatory, you will be entitled to benefits if you complete the second treatment.**

17. Dental Benefits - Indemnity PPO Plan, and HMO Eligible Participants

If you are eligible for medical benefits under Plan A, then you are also eligible for the Plan's choice of two dental Plans offered through Delta Dental of California. When you become eligible for medical benefits, you will be asked by the Trust Fund Office to enroll in the dental plan of your choice. Certain dental procedures and facility charges incurred on an emergency basis as a result of a non-occupational bodily injury may be covered through your major medical benefits under limited circumstances.

a. **DeltaCare USA (PMI):**
The PMI plan features a large network of dentists with most services at no cost to you, including orthodontic coverage. Treatment **must** be provided by a DeltaCare USA Panel Dentist. Member is responsible for any deductibles or co-payments.

You must obtain all dental, orthodontic and other dental-related procedures from a listed participating dental provider. A complete listing of dentists, orthodontists and other participating providers as well as a list of covered procedures, exclusions, and the member's co-payment obligation per procedure can be obtained from Delta Dental of California at (800) 765-6003.

b. ***Delta Preferred OptionUSA (DPO):***
The Delta Preferred Option USA (DPO) plan features the largest network of dentists in California for in network benefits and allows you to go to any dentist of your choice for out-of-network benefits. However, only 70% of DPO approved fees will be covered to a dentist out-of-network instead of 80% of DPO approved fees to an in-network dentist.

See Current Reference Guide for co-pay schedules.

18. Vision Benefits-Indemnity PPO Plan and HMO Eligible Participants

If you and your eligible dependents qualify for Plan A medical benefits either through the Indemnity PPO Plan or one of the Plan's HMOs, you may receive Vision benefits from the provider of your choice and submit your claim directly to the Trust Fund Office. Covered claims will be reimbursed up to the Plan maximums allowed under the following Schedule of Benefits. Vision benefits are not subject to Plan Deductibles / Coinsurance.

The plan pays for one examination (refraction) by a licensed ophthalmologist or optometrist up to $50 per examination during each 12 month period. HMO participants and their eligible dependents must use an HMO provider for vision exams (refraction). If your HMO does not cover refraction for contact lenses, you may receive this type of exam from a non-HMO provider and submit the claim directly to the Trust Fund Office for consideration. If your claim for contact lens refraction is covered by the Plan, it will be paid at the reimbursement maximum stated above.

The plan pays for one (1) pair of lenses or contact lenses in each 12 Consecutive Month Period and one (1) set of frames every 24 months based on the following schedule:

Single Vision Lenses	$70
Bifocal Lenses	$90
Trifocal Lenses	$110
Lenticular Lenses	$140
Contact Lenses/pair	$120
Frames (once every 24 months)	$110

No benefits are payable for:

a. Expenses for any services or supplies covered by any other part of the Plan;

b. Special procedures such as
   1. orthoptics,
   2. vision training,
   3. subnormal vision aids,
   4. plain sunglasses,
   5. anti-reflective or anti-scratch coatings,
   6. special vision testing except as provided by an ophthalmologist or optometrist,
   7. medical or surgical treatment of the eyes, or
   8. services or supplies not listed as covered expenses.
   9. LASIK and/or Radial Keratotomy and other surgical vision procedures
   10. Photochamatic lenses (Transition Lenses)

c. Expenses otherwise excluded or limited by the Plan.
   If, as a result of covered surgical treatment of the eye(s), there is a change in prescription needed to correct vision, the Trust will reimburse for both lenses and frames as necessary without the need to wait for the above 12/24 month limitation periods to expire. This benefit extension does not include changes in vision due to surgeries for cosmetic or elective treatments, including but not limited to Radial Keratotomy and LASIK. Contact the Trust Fund Office at (800) 752-2394 for further details.

19. Hearing Aid Benefits – Indemnity PPO Plan and HMO Plans

Benefit Schedule – Not subject to Plan Deductibles/Coinsurance

Benefit	*Plan Covers*
Hearing Aids	Up to $1,500 per Aid
Aid Replacement	Every 4 Years If Needed
Exams*	Up to $75 Per Year
Molds	Up to $50 Per Mold
Mold Replacement	Twice Per Year if Needed

*Applies to Indemnity PPO Plan Eligible Participants; HMO Eligible Participants must receive their hearing aid exam through their HMO.

20. Prescription Benefits Indemnity PPO Plan and Aetna Eligibles - See Section 6

21. Death Benefits – Indemnity PPO Plan and HMO Eligibles – See Section 7

B. SCHEDULE OF COVERAGE - INDEMNITY PPO PLAN "B'

The following is a description of the benefits available to eligible participants covered under Indemnity PPO Plan B. If you are in Plan B and have chosen an HMO plan, most of your benefits are provided by your HMO and are described in a booklet that can be obtained from your HMO or the Trust Fund Office. This section also describes the Plan B Dental, Orthodontia, Vision (other than refraction), and Hearing Aid (other than examination) benefits that apply to eligible participants enrolled in Plan B.

Major Medical Expense Benefits

1. Lifetime Maximums: There is no lifetime maximum.

2. Deductible: $250 per Calendar Year per Individual and $750 per Calendar Year per Family.

3. Annual Out of Pocket Maximum:
   $4,000 per person - 100% of eligible expenses will be paid after you have had eligible out of pocket expenses of $4,000 in a calendar year. All remaining eligible expenses for that year will be reimbursed at up to 100% of UCR charges or 100% of the PPO rate when using PPO Providers.

4. Levels of Reimbursement:

   a. Using PPO Provider and Pre-Admission Review Procedures:
   80% of the PPO Rate is paid when using PPO Providers and Hospitals.

   The PPO Provider Network is a voluntary, optional program to you. If you use a PPO network provider, your benefit will be increased to 80% of the PPO contract rates rather than the 60% of Usual, Customary & Reasonable (UCR) charges. You must use Pre-Admission Review Procedures, when required, to receive 80%. For Information on the Preferred Providers in your area you may contact the Trust Fund Office at (800) 752-2394 or research for PPO providers at www.anthem.com.

   b. Using Non-PPO Provider and Pre-Admission Review Procedures:
   60% of UCR when using non-PPO Providers as long as Pre-Admission Review Procedures were followed when required.

   Non-PPO Providers means hospitals, physicians, chiropractors, other health care professionals, and providers of ancillary services who do not participate in the PPO network through the Anthem Blue Cross Prudent Buyer plan (Non-PPO providers receive a lower level of reimbursement. Please see below.)

   Non-PPO Hospital includes in-patient, out-patient and emergency room services provided by a non-PPO Hospital.

   Pre-admission review rules must be followed when required.

Failure to obtain a Pre-Admission Review or emergency admission review may result in a denial of benefits or benefit reduction.

5. Ground Ambulance Service:

Licensed ground ambulance service to transport a covered person to the nearest facility qualified to treat the sickness or injury. While the regular percentage co-payment normally applies to Ground Ambulance Service, 100% of UCR charges for ground ambulance cost will be paid to transfer a patient from a non-Preferred Provider Hospital to a Preferred Provider Hospital which is within 50 miles of the non-Preferred Provider Hospital when the transfer is approved by the attending physician and by the Managed Care Department.

6. Second Surgical Opinion:

100% of the Usual, Customary & Reasonable (UCR) charges for a second opinion for surgery when the second opinion is arranged by the Managed Care Department. Telephone (800) 274-7767.

7. Hospital Room & Board:

a. Using PPO and Pre-Admission Review Procedures:
80% of Anthem Blue Cross PPO contract rare if a PPO hospital is used and Pre-Admission Procedures are followed.

b. Using Non-PPO Provider and Pre-Admissions Review Procedures:
60% of UCR if non-PPO Hospital is used and Pre-Admission Review procedures are followed.

Failure to obtain a Pre-Admission Review or emergency admission review may result in a denial of benefits or benefit reduction.

8. Convalescent / Home Health Care / Skilled Nursing Facility / Hospital Daily Rate
This is a combined benefit:

Confinement must begin within 14 days after the end of confinement of at least 3 days in a hospital and must be for the same sickness or injury causing the preceding hospitalization. Confinement must not be for custodial care. Covered:

a. $100 per day to a maximum of 60 days per admission. (The $100 maximum does not apply for convalescent services at a skilled nursing facility)

b. Services and supplies which are furnished for medical care therein.

9. Hospice Care – for patients with terminal prognosis up to 6 months maximum

10. California End of Life Option Act – For patients 18 years of age or older, mentally competent and diagnosed with a terminal illness that will, within reasonable medical judgment, lead to death within six (6) months.

11. Outpatient Surgical Facility

Non-PPO Rates by county

County (where facility located):	**Maximum Rate Per Surgery:**
Los Angeles/Orange/San Diego:	$2,900 (Plan pays 60%)
Riverside/San Bernardino	$2,450 (Plan pays 60%)
San Luis Obispo/Santa Barbara/Kern:	$1,910 (Plan pays 60%)
Ventura:	$2,340 (Plan pays 60%)

12. Outpatient Psychotherapy and Psychometric testing

a. ***Using PPO Provider and Pre-Admission Review Procedures:***
80% of the PPO Rate is paid when using PPO Providers

b. ***Using Non-PPO Provider and Pre-Admission Review Procedures:***
60% of UCR when using non-PPO Providers

13. Inpatient Mental Health Benefits

a. ***Using PPO Provider and Pre-Admission Review Procedures:***
80% of Anthem Blue Cross PPO contract rate if a PPO Hospital or mental health/substance abuse facility is used and Pre-Admission Procedures followed.

b. ***Using non-PPO Provider and Pre-Admission Review Procedures:***
60% of UCR if non-PPO Hospital or non PPO Mental Health / Substance Abuse Facility is used and Pre-Admission Review procedures are followed.

Failure to obtain a Pre-Admission Review or emergency admission review may result in a denial of benefits or benefit reduction.

14. Chiropractic Care, Physical Therapy and Acupuncture

(The Physical Therapy, Acupuncture and Chiropractic, benefits are combined for purposes of applying the maximum number of services, which is 25 visits per calendar year)

a. ***Using PPO Provider***
80% of the PPO rate when PPO Chiropractor, Physical Therapist (PT) or Acupuncturist is used.

b. **Using Non-PPO Provider**
60% of UCR charges when non-PPO Chiropractor, PT or Acupuncturist is used.

The Plan shall pay no more than $100 per participant for medically necessary x-rays for chiropractic in a calendar year.

15. Routine Physical Exams and Gynecological Care Services:

The Plan allows one routine physical examination and gynecological visit every 12 months.

16. Smoking Cessation:

The smoking cessation benefit will allow you to receive smoking cessation products through the Trust's prescription program administered by Optum Rx. OTC (over the counter) nicotine replacement products require a physician's prescription. Nicotine replacement therapy is limited to two (2) courses of treatment per lifetime. Covered products will include both prescription and over-the-counter nicotine replacement products. Covered purchases will be subject to the current prescription co-pay of $10 for a 30-day supply.

First Treatment
In order to be eligible to receive or be reimbursed for the smoking cessation products for your initial course of treatment, you must provide the pharmacist or Trust Fund Office with physician's prescription.

Second Treatment
In order to be eligible to receive or be reimbursed for the smoking cessation products for your second course of treatment, you must provide the pharmacist or Trust Fund Office with a physician's prescription. You must also show proof of purchase of a smoking cessation course such as "Smokenders".

The Trust will reimburse up to two (2) courses of treatment per lifetime upon your submission of your proof-of-purchase of a smoking cessation course. **Although the first course of treatment is not mandatory, you will be entitled to benefits if you complete the second Treatment.**

17. Dental Benefits-Indemnity PPO Plan and HMO Eligible Participants

If you are eligible for medical benefits under Plan B, then you are also eligible for the Plan's dental benefit through DeltaCare USA. When you become eligible for medical benefits, you will be asked by the Trust Fund Office to enroll in DeltaCare USA. You must obtain all dental, orthodontic and other dental-related procedures from your selected participating dental provider. A complete listing of dentists, orthodontists and other participating providers as well as a list of covered procedures, exclusions, and the member's co-payment obligation per procedure can be obtained from DeltaCare USA at (800) 422-4234. Certain dental procedures and facility charges incurred on an emergency basis as a result of a non-occupational bodily injury may be covered under limited circumstances.

a. **DeltaCare USA (PMI)**

The PMI plan features a large network of dentists with most services at no cost to you, including orthodontic coverage. Treatment **must** be provided by a DeltaCare USA Panel Dentist. Member is responsible for any deductibles or co-payments.

You must obtain all dental, orthodontic and other dental-related procedures from a listed participating dental provider. A complete listing of dentists, orthodontists and other participating providers as well as a list of covered procedures, exclusions, and the member's co-payment obligation per procedure can be obtained from Delta Dental of California at (800) 765-6003.

See Current Reference Guide for Co-pay schedules.

18. Vision Benefits - Indemnity PPO Plan and HMO Eligible Participants

If you and your eligible dependents qualify for Indemnity PPO Plan B medical benefits either through the Indemnity PPO Plan or one of the Plan's HMOs, you may receive Vision benefits from the provider of your choice and submit your claim directly to the Trust Fund Office. Covered claims will be reimbursed up to the Plan maximums allowed under the following Schedule of Benefits. Vision benefits are not subject to Plan Deductibles / Coinsurance.

The plan pays for one examination (refraction) by a licensed ophthalmologist or optometrist up to $50 per examination during each 12 month period. HMO participants and their eligible dependents must use an HMO provider for vision exams (refraction). If your HMO does not cover refraction for contact lenses, you may receive this type of exam from a non-HMO provider and submit the claim directly to the Trust Fund Office for consideration. If your claim for contact lens refraction is covered by the Plan, it will be paid at the reimbursement maximum stated above.

The plan pays for one (1) pair of lenses or contact lenses in each 12 consecutive month period and one (1) set of frames in every 24 months based on the following schedule:

Single Vision Lenses	$70
Bifocal Lenses	$90
Trifocal Lenses	$110
Lenticular Lenses	$140
Contact Lenses/pair	$120
Frames (once every 24 months)	$110

No benefits are payable for:

a. Expenses for any services or supplies covered by any other part of the Plan;

b. Special procedures such as

1. orthoptics,

2. vision training,

3. subnormal vision aids,

4. plain sunglasses,

5. anti-reflective or anti-scratch coatings,

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

7. medical or surgical treatment of the eyes,

8. services or supplies not listed as covered expenses, or

9. LASIK and/or Radial Keratotomy and other surgical vision correction procedures.

10. Photochamatic Lenses (Transition Lenses)

c. Expenses otherwise excluded or limited by the Plan.

If, as a result of covered surgical treatment of the eye(s), there is a change in prescription needed to correct vision, the Trust will reimburse for both lenses and frames as necessary without the need to wait for the above 12/24 month limitation periods to expire. This benefit extension does not include changes in vision due to surgeries for cosmetic or elective treatments, including but not limited to Radial Keratotomy and LASIK. Contact the Trust Fund Office at (800) 752-2394 for further details.

19. Hearing Aid Benefits – Indemnity PPO Plan and HMO Plans

Benefit Schedule – Not subject to Plan Deductibles / Coinsurance

Benefit	**Plan Covers**
Hearing Aids	Up to $1,500 per Aid
Aid Replacement	Every 4 Years If Needed
Exams*	Up to $75 Per Year
Molds	Up to $50 Per Mold
Mold Replacement	Twice Per Year if Needed

*Applies to Indemnity PPO Plan Eligibles Participants; HMO Eligible Participants must receive their hearing aid exam through their HMO.

20. Prescription Benefits - Indemnity PPO Plan and Aetna members only - See Section 6

21. Death Benefits – Indemnity PPO Plan and HMO Eligibles – See Section 7

C. SCHEDULE OF COVERAGE – INDEMNITY PPO PLAN "C"

The following is a description of the benefits available to eligible participants covered under Indemnity PPO Plan C. If you are in Plan C and have chosen an HMO plan, most of your benefits are provided by your HMO and are described in a booklet that can be obtained from your HMO or the Trust Fund Office.

Major Medical Expense Benefits

1. Lifetime Maximums:

   There is no lifetime maximum.

2. Deductible:

   $250 per Calendar Year per Individual and $750 per Calendar Year per Family.

3. Annual Out of Pocket Maximum:

   $4,000 per person - 100% of eligible expenses will be paid after you have had eligible out of pocket expenses of $4,000 in a calendar year. All remaining eligible expenses for that year will be reimbursed at up to 100% of UCR charges or 100% of the PPO rate when using PPO Providers.

4. Levels of Reimbursement:

   a. Using PPO Provider and Pre-Admission Review Procedures:
   70% of the PPO Rate is paid when using PPO Providers.

   The PPO Provider Network is a voluntary, optional program to you. If you use a PPO network provider, your benefit will be increased to 70% of the PPO contract rates rather than the 50% of Usual, Customary & Reasonable (UCR) charges. You must also use Pre-Admission Review Procedures, when required, to receive 70%. For Information on the Preferred Providers in your area you may contact the Trust Fund Office at (800) 752-2394, or search for PPO providers at www.anthem.com.

   b. Using PPO Provider and Pre-Admission Review Procedures:
   50% of UCR when using non-PPO Providers as long as Pre-Admission Review Procedures were followed when required.

   Non-PPO Providers means hospitals, physicians, chiropractors, other health care professionals, and providers of ancillary services who do not participate in the PPO network through the Anthem Blue Cross Prudent Buyer plan (Non-PPO providers receive a lower level of reimbursement. Please see below.)

   Non-PPO Hospital includes in-patient, out-patient and emergency room services provided by a non-PPO Hospital.

Pre-Admission Review rules must be followed when required. **Failure to obtain a Pre-Admission Review or emergency admission review may result in a denial of benefits or benefit reduction.**

5. Ground Ambulance Service:

Licensed ground ambulance service to transport a covered person to the nearest facility qualified to treat the sickness or injury. While the regular percentage co-payment normally applies to Ground Ambulance Service, 100% of UCR charges for ground ambulance cost will be paid to transfer a patient from a non-Preferred Provider Hospital to a Preferred Provider Hospital which is within 50 miles of the non-Preferred Provider Hospital when the transfer is approved by the attending physician and by the Managed Care Department**.**

6. Second Surgical Opinion:

100% of the Usual, Customary & Reasonable Charges (UCR) for a second opinion for surgery when the second opinion is arranged by Managed Care Utilization Review Department (800) 274-7767.

7. Hospital Room & Board:

a. ***Using PPO and Pre-Admission Review Procedures:***
70% of Anthem Blue Cross PPO contract rate if a PPO hospital is used and Pre-Admission Procedures are followed.

b. ***Using Non-PPO Provider and Pre-Admissions Review Procedures:***
50% of UCR if non-PPO Hospital is used and Pre-Admission Review procedures are followed.

Failure to obtain a Pre-Admission Review for emergency admission review may result in a denial of benefits or benefit reduction.

8. Convalescent / Home Health Care / Skilled Nursing Facility / Hospital Daily Rate
This is a combined benefit:

Confinement must begin within 14 days after the end of confinement of at least 3 days in a hospital and must be for the same sickness or injury causing the preceding hospitalization. Confinement must not be for custodial care. Covered:

1. $100 per day to a maximum of 60 days per admission. (The $100 maximum does not apply for convalescent services rendered at a skilled nursing facility.)

2. Services and supplies which are furnished for medical care therein.

9. Hospice Care – For patients with terminal prognosis up to 6 months maximum.

10. California End of Life Option Act – For patients 18 years of age or older, mentally competent and diagnosed with a terminal illness that will, within reasonable medical judgment, lead to death within six (6) months.

11. Outpatient Surgical Facility:

Non-PPO rates by county

County (where facility located):	**Maximum Rate Per Surgery:**
Los Angeles/Orange/San Diego:	$2,900 (Plan pays 50%)
Riverside/San Bernardino	$2,450 (Plan pays 50%)
San Luis Obispo/Santa Barbara/Kern:	$1,910 (Plan pays 50%)
Ventura:	$2,340 (Plan pays 50%)

12. Outpatient Psychotherapy and Psychometric testing:

a. ***Using PPO Provider and Pre-Admission Review Procedures:***
70% of the PPO Rate is paid when using PPO Providers.

b. ***Using Non-PPO Provider and Pre-Admission Review Procedures:***
50% of UCR when using non-PPO Providers

13. Inpatient Mental Health Benefits

a. ***Using PPO Provider and Pre-Admission Review Procedures:***
70% of Anthem Blue Cross PPO contract rate if a PPO Hospital or mental health / substance abuse facility is used and Pre-Admission Procedures are followed.

b. ***Using non-PPO Provider and Pre-Admission Review Procedures:***
50% of UCR if non-PPO Hospital or mental health / substance abuse facility is used and Pre-Admission Procedures are followed.

Failure to obtain a Pre-Admission Review or emergency admission review may result in a denial of benefits or benefit reduction.

14. Chiropractic Care, Physical Therapy, and Acupuncture:

(The Physical Therapy, Acupuncture and Chiropractic, benefits are combined for purposes of applying the maximum number of services, which is 25 visits per calendar year)

a. ***Using PPO Provider***
70% of the PPO rate when PPO Chiropractor, Physical Therapist (PT), or Acupuncturist is used.

b. ***Using Non-PPO Provider***
50% of Usual, Customary & Reasonable (UCR) charges when non-PPO Chiropractor, Physical Therapist (PT) or Acupuncturist is used.

The Plan shall pay no more than $100 per participant for medically necessary x-rays for chiropractic in a calendar year.

15. Routine Physical Exams and Gynecological Care Services:

The Plan allows one routine physical examination and gynecological visit every 12 months.

16. Smoking Cessation:

The smoking cessation benefit will allow you to receive smoking cessation products through the Trust's prescription program administered by Optum Rx. OTC (over the counter) nicotine replacement products require a physician's prescription. Nicotine replacement therapy is limited to two (2) courses of treatment per lifetime. Covered products will include both prescription and over-the-counter nicotine replacement products. Covered purchases will be subject to the current prescription co-pay of $10 for a 30-day supply.

First Treatment
In order to be eligible to receive or be reimbursed for the smoking cessation products for your initial course of treatment, you must provide the pharmacist or Trust Fund Office with a doctor's physician's prescription.

Second Treatment
In order to be eligible to receive or be reimbursed for the smoking cessation products for your second course of treatment, you must provide the pharmacist or Trust Fund Office with a physician's prescription. You must also show proof of purchase of a smoking cessation course such as "Smokenders".

The Trust will reimburse up to two (2) courses of treatment per lifetime upon submission of your proof-of-purchase of a smoking cessation course. **Although the first course of treatment is not mandatory, you will be entitled to benefits if you complete the second treatment.**

17. Dental Benefits – Not available for Participants in Plan C.

18. Vision Benefits – Not available for Participants in Plan C.

19. Hearing Aid Benefits – Indemnity PPO and HMO Plans

Benefit Schedule – Not subject to Plan Deductibles / Coinsurance

Benefit	**Plan Covers**
Hearing Aids	Up to $1,500 per Aid
Aid Replacement	Every 4 Years if Needed
Exams*	Up to $75 Per Year
Molds	Up to $50 Per Mold
Mold Replacement	Twice Per Year if Needed

*Applies to Indemnity PPO Plan Eligible Participants; HMO Eligible Participants must receive their hearing aid exam through their HMO.

20. Prescription Benefits- Indemnity PPO Plan and Aetna Eligibles – See Section 6

21. Death Benefits – Indemnity PPO Plan Participants and HMO Eligible – See Section 7

SECTION 6
PRESCRIPTION BENEFITS

Prescription Benefits- Indemnity PPO Plan and Aetna Participants only

If you have Kaiser Coverage, contact Kaiser regarding your Prescription Benefits. Your Kaiser medical card will also serve as your Kaiser Prescription card.

All participants who are eligible for medical benefits are also eligible for prescription benefits. Prescription drug means a drug requiring, and obtainable only through, the written prescription of a licensed physician. Medications available without a prescription or those with Over-the-Counter (OTC) equivalents are not covered. The prescription program is serviced by Optum Rx. Whenever the participant needs a prescription, you should go to one of Optum Rx' participating pharmacies, tell the pharmacist you have the Optum Rx program, present your Optum Rx Drug ID Card, then provide the pharmacist with your name, social security number, and the Plan's group number which is **#074**. The pharmacist should then be able to verify the member's eligibility under this program.

Optum Rx Drug Card

Out of Pocket Charges Using a Retail Pharmacy Per Prescription:

1. $10 for Generic medication
2. $15 for Formulary Brand Name medication
3. $20 Non-Formulary Brand Name medication

The Participating Pharmacy will fill your prescription and provide you with up to a 30-day supply of most medication. The cost of the prescription will be based on a discount negotiated by Optum Rx. To reduce your co-pay, you should use generic and formulary brand name drugs whenever possible.

The Trust does not require participants to use the Optum Rx program. However, a participant does not use the program, he / she will have to pay for the full retail cost of the prescriptions up front then submit a claim form to the Trust for reimbursement under the Indemnity PPO Plan. Certain deductibles and co-payments will apply to these claims. The maximum you can be reimbursed for an out-of-network prescription is 80% of the Usual, Customary and Reasonable (UCR) charge for such a prescription.

If you have any questions or need help in locating a participating pharmacy, please call Optum Rx at (800) 788-7871.

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

Optum Rx Mail Service

This is a program designed to provide further savings for maintenance-type prescription drugs through a mail order program. This program allows you to purchase up to a 90-day supply of a prescription drug. To use this program, obtain a Prescription Drug Mail Order form and follow the directions on the form. Please call the Trust Fund Office or Optum Rx at (800) 788-7871 to obtain a Mail Service Prescription Drug order form.

Out Of Pocket Charges Per Prescription Using Mail Order Service:

1. Generic: $20 (90-day supply)
2. Formulary Brand Name: $30 (90-day supply)
3. Non-Formulary Brand Name: $40 (90-day supply)

The following injectable drugs are covered (at retail only):

1. Epi-Pens and Ana-Kit
2. Imitrex (retail only)
3. DHE-45 (retail only)
4. Acthar Gel (retail only)
5. Rebetron Kit (retail only)
6. Interferon (Actimmune, Alferon-N, Avonex, Infergen, Intron-A, Roferon-A)

EXCLUSIONS: NOTE SUBJECT TO REVIEW BY OPTUM

1. Medications available without a prescription or those with OTC equivalents are not covered
2. Medications purchased outside the United States are not covered
3. Therapeutic devices or appliances including hypodermic needles, pen needles, syringes (except for insulin), support garments and other non-medicinal substances are not covered
4. Prescriptions administered by an institution are not covered
5. Injectable drugs unless listed as covered
6. Anabolic steroids
7. Growth hormones
8. Fertility drugs
9. Prescription vitamins or dietary supplements (except prenatal vitamins)
10. Anti-obesity or Anorexiants

11. Hair growth stimulants

12. Blood and blood derivatives

13. Normal Saline for Irrigation

14. Unit dose packaging (unless only available as unit dose)

15. All Erectile Dysfunction drugs (e.g., Cialis, Levitra, Viagra, Muse, Yohimbine) except when medically necessary and authorized by a physician

16. T.R.U.E Test

17. Alternative medications

18. Prescription Misc. Nutritional Substances & Nutritional Supplements

19. Blood Glucose Monitors

COMPOUNDS

1. Compounds are covered but must contain at least one covered, federal legend or state restricted drug.

2. Pharmacies must submit using the NDC of the most expensive ingredient.

3. Compounds will be reimbursed at the submitted cost minus non-formulary copay.

Payment as Secondary Insurance

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

SECTION 7
DEATH BENEFITS

DEATH BENEFITS -- BASED ON CURRENT ELIGIBILITY FOR HEALTH INSURANCE

IMPORTANT NOTE - Non-bargaining Employees are not eligible for death benefits**.**

Active Employees
An employee is considered an active employee if he or she had some contributions made to the Fund on his or her behalf.

Eligibility for Active Employees
Benefits will be paid with respect to an active employee's death or dismemberment, or the death of one of the active employee's dependents provided at least one of the following conditions is met:

1. Contributions have been made on the active employee's behalf for a minimum of 165 hours in the six month period immediately prior to the month in which the death or dismemberment occurs. These contributions must be spread over any three of these six months; or

2. Contributions have been made on the active employee's behalf for a minimum of 500 hours in the twelve month period immediately prior to the month in which the death or dismemberment occurs.

If the active employee was age 60 or over when the first contribution to the Fund was made on his behalf, condition (b) above must be satisfied.

Benefits for Active Employees and Their Dependents

1. ACTIVE EMPLOYEES

   (a) In the event of death from any cause except suicide or an act of war, the benefit is **$7,500**.*

   (b) In the event of accidental death, there is an additional benefit of **$7,500**.**

   (c) For loss of any two members of the body through accident (hands, feet, eyes or combination) the benefit is **$7,500**.**

   (d) For loss of any one member of the body through accident (hand, foot or eye) the benefit is **$3,750**.**

2. DEPENDENTS OF ACTIVE EMPLOYEES

   (a) In the event of the death of the legal spouse of an eligible active employee for any cause except suicide or an act of war, the benefit is **$2,000**.*

(b) In the event of the death of an unmarried child of an eligible active employee, including a stepchild or a legally adopted child, from 6 months to 19 years of age from any cause except suicide or an act of war, the benefit is **$2,000**.*

(c) In the event of death from any cause except an act of war, of an unmarried child of an eligible active employee, including a stepchild or a legally adopted child, less than 6 months of age, the benefit is **$100**.

* In case of suicide, the death benefit will be paid only if the employee has been eligible for a benefit under this Plan for at least 24 months. The benefit is not payable if death is caused by an act of war.

** Not payable for losses resulting from self-inflicted injuries, riot, war, disease, certain aviation accidents or commission of a felony by an eligible participant or dependent**.**

LOSS OF ELIGIBILITY

Failure to satisfy the hour's requirements for eligibility as an active employee will result in a loss of eligibility for benefits as an active employee.

Inactive Employees
The death of an inactive employee or the death of a dependent of an inactive employee will result in the payment of a death benefit if the inactive employee meets the following condition at the time of death: if, on the first day the Employee no longer meets the conditions for being an active employee, that employee is then eligible for the immediate payment of a normal or early retirement (or becomes eligible for payment of a Disability Retirement within five months of losing eligibility for active employee coverage) from the International Painters and Allied Trades Industry Pension Plan (United States), then the employee shall be deemed an inactive employee.

1. Benefits for Inactive Employees

a) In the event of death from any cause except suicide or an act of war, the benefit is **$2,000.***

2. Dependents of Inactive Employees

a) In the event of the death of the legal spouse of an eligible inactive employee for any cause except suicide or an act of war, the benefit is **$1,500.***

b) In the event of the death of an unmarried child of an eligible inactive employee, including a stepchild or a legally adopted child, from 6 months to 19 years of age from any cause except suicide or an act of war, the benefit is **$1,500.***

c) In the event of death from any cause except an act of war, of an unmarried child of an eligible inactive employee, including a stepchild or a legally adopted child, less than 6 months of age, the benefit is **$100.**

* In case of suicide, the death benefit will be paid only if the employee has been eligible for a benefit under this Plan for at least 24 months. The benefit is not payable if death is caused by an act of war.

Payment of Benefits – Beneficiaries

A benefit with respect to the death of an Employee, will be paid to the person last designated as Beneficiary by the Employee on a special Beneficiary Designation Form prepared by and filed with the Trust Fund Office. Only natural persons may be so designated and benefits will only be paid to such natural persons. However, a participant may designate a Trust Fund if the Trustees determine, in their sole discretion, that the primary purpose of said Trust Fund is to benefit natural persons. If the beneficiary designation fails to comply with these provisions, it shall be null and void.

If an Employee has not designated a Beneficiary or if the designation is void, then the benefit will be paid to a participant's family members in the following order of succession:

1. Spouse – but if no spouse is living at the time of distribution then the benefit will be paid to

2. Children - (divided equally among those then living at the time of distribution) but if no children are living at the time of distribution, then the benefit will be paid to

3. Parents - (divided equally among those then living at the time of distribution) but if no parent is living at the time of distribution, then the benefit will paid to

4. Brothers and sisters - (divided equally among those living at the time of distribution)

The Trustees, in their sole discretion, may pay a benefit (otherwise payable to a person in one of the above-listed categories) to a Trust Fund primarily for the benefit of such a person. If there are no beneficiaries in the above listed categories who are alive at the time of distribution, no death benefit shall be paid.

SECTION 8
EMPLOYEE ELIGIBILITY FOR HEALTH & WELFARE BENEFITS

Read this section carefully and make an informed selection. If you pick a level that you cannot support because you do not work enough hours, you may lose coverage. Know the Plan's eligibility rules – your coverage may depend on it.

APPLICATION FORM FOR EMPLOYEE COVERAGE

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

NON-BARGAINING UNIT EMPLOYEES

Non-Bargaining Unit Employee – An employee working for a contributing employer in a non-bargaining unit job classification. A non-bargaining unit employee who works at least 20 hours per week shall become eligible for coverage on the first day of the month following the month in which they complete 30 days of continuous employment for the Contributing Employer.

Non-bargaining unit employees are not eligible for Reserve Contribution Credits nor are they eligible for a Death Benefit through this Plan.

ELIGIBLE CLASSES OF EMPLOYEES

When you work in covered employment for an employer signatory to a labor agreement with the Southern California Painters & Allied Trades District Council 36, contributions may be made into this Plan on your behalf. These contributions are used to determine eligibility for you and your eligible dependents.

Some employers contribute into the Plan on a per hour basis and some employers contribute into the Plan a fixed amount per month if you work the required hours or days in a month.

WHEN COVERAGE BECOMES EFFECTIVE

If you are a new Employee, or if you previously lost eligibility, you become eligible for Employee coverage on the first day of the fifth month of a period that begins with three continuous months during which you accumulate the minimum hours for the level that you have selected, so long as you are credited with at least 25 hours in the first month.

The following examples reflect how eligibility for coverage is determined

	Plan Level A	Plan Level B	Plan Level C
Benefit Credits / Hours Needed	140	120	100
***Hours Needed x Hourly Contribution (Primary) Rate of $8.05**	1,127	966	805
Maximum Hour Bank You Could Earn	4,508	3,864	3,220

* Effective work month of October 2016 and eligibility month of January 1, 2017 (H&W rate of $8.05)

* Effective work month of October 2016 and eligibility month of January 1, 2017 (H&W rate of $8.05)

* If you work under other rates or a combination of rates, the total dollars contributed per month will determine your eligibility.

The contribution rate for non-bargaining employees is established by the Board of Trustees and is subject to the change from time to time.

ELIGIBILITY AND PLAN LEVEL SELECTION

When a member establishes eligibility, he / she will be enrolled in the default Medical Plan, which is the Indemnity PPO Plan Level C. If the eligible member does not want to remain in the Indemnity Plan Level C; an Enrollment Form must be submitted within 90 days after establishing eligibility, wherein the member selects the desired Medical Plan and Plan Level for the next 12 months. The member has the option of lowering the Plan Level during the year as many times as needed. However, the member can only select a higher Plan Level after he or she has been enrolled in their initial or current Plan Level for 12 consecutive months. An Enrollment Form must be submitted selecting the new Plan Level prior to the eligibility month. The Plan Level change will not be done automatically. If the member does not have sufficient credits to remain eligible at the *Plan Level selected. In such event he / she will lose coverage. The Plan Level Change will not be granted if requested after coverage is terminated.* (If there is a difference between the hours you have worked and the contribution your employer has made towards your benefits, you may have to submit check stubs to the Trust Fund Office.)

If a member loses coverage and has bank hours and / or elects COBRA, then returns to work with no lapse or lapse in coverage, the initial eligibility requirements don't apply if the member re-instates coverage within six (6) months.

In addition, if a member, through COBRA, maintains the full package of benefits in which he participated immediately before the COBRA "Qualifying Event", any Reserve Benefit Credits in the bank will be carried forward for a maximum of six months. Any hours the member works during that six month period will be added to the hour bank helping the member regain eligibility under the bank rules. In the event the member does not accumulate the hours requires to regain eligibility within the six month period, the member will

loose the remaining Reserve Benefit Credits in the hour bank balance. However, your COBRA rights will continue.

The member will have the opportunity to change Medical Plans and to upgrade Plan Levels if he / she has been enrolled in their initial Medical / Dental Plan or current Plan Level for 12 consecutive months.

Having three Plan levels enables you to select an affordable level of coverage for the year ahead based on the hours you expect to work. The three Plan Levels have the same Major Medical Benefit options, e.g., an Indemnity PPO Plan or one of two HMOs. In addition to the amount payable by the Indemnity PPO Plan for covered services, or the HMO's member co-pay amounts if you choose an HMO, the main differences in the three Plan Levels are the availability and amount of Dental coverage provided, and the availability of Vision, Chiropractic, and Substance Abuse Detoxification benefits. (For further details, a Plan Comparison Chart is available from the Trust Fund Office.)

Coverage will become effective once:

1. you have submitted a completed enrollment form; and

2. you have worked enough hours to become eligible.

WHEN A CHANGE IN EMPLOYEE COVERAGE BECOMES EFFECTIVE

Increases or decreases in your level of coverage are effective on the first of the month following the month in which your request to change is approved by the Trust Fund Office.

WHEN EMPLOYEE COVERAGE ENDS

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

1. the date this Plan ends;

2. the date you become ineligible because of amount of hours worked;

3. the date you begin active duty in the armed forces unless the period of military leave is less than thirty-one (31) days.

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

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

CONTRIBUTION CREDIT BANK

Banking of Hours and Reserve Contribution Credits

1. If your employer contributes to the Plan on a per hour basis, all hours contributed for you are used to calculate your Contribution Credits, then are used to provide for your monthly coverage. Credits earned above the amount needed to provide for your selected level of coverage on a monthly basis are banked as Reserve Contribution Credits.

2. If you work more hours than are necessary to earn the Contribution Credits required for the Plan Level of coverage you have selected, you will accumulate Reserve Contribution Credits in the Credit Bank. These Credits will be used if you don't otherwise have enough work hours to maintain eligibility until there are insufficient credits remaining in your Bank to use for a month's eligibility. At that time you will become ineligible for coverage. (See "Continuation of Coverage" Section for possible options).

3. Eligibility for coverage can be maintained by a combination of hours earned and credits available in your Contribution Credit Bank. Unused credits can be maintained indefinitely in the Credit Bank as long as you are an eligible participant in the Plan (and the Board of Trustees continues to offer the Credit Bank as a feature of this Plan).

Limitations to the Contribution Credit Bank

A member can accumulate a maximum of four (4) months of Benefit Credits / Hours in their Benefit Credit / Hour Bank. If a member works more hours than are necessary to earn the Benefit Credits / Hours required for the level of coverage he / she selected, he / she will accumulate reserve Benefit Credits / Hours in the Benefit Credits / Hour Bank. These Benefit Credits / Hours will be used if the member does not have enough work hours to maintain eligibility, until there are insufficient credits to use for a month's eligibility.

A member will begin banking hours immediately upon initial eligibility.

1. You may accumulate up to four (4) months of coverage in your Credit Bank.

2. If you do not have sufficient Contribution Credits to maintain eligibility, and thus would otherwise lose Plan coverage, if you qualify, you may self-pay the full cost of coverage for that month, use the "Buy-Up" option, or use COBRA to continue your coverage for limited periods of time. These options are explained in the "Continuation of Coverage" Section below.

3. In addition, if through one of the above-mentioned options, you maintain the full package of benefits in which you participated immediately before you utilized a "Buy Up" or COBRA option, any Reserve Contribution Credits in your Contribution Credit Bank will be carried forward for a maximum of six months. Any hours you work during that six month period will be added to your Credit Bank helping you to regain eligibility under the Credit Bank rules above. In the event you do not accumulate the hours required to regain eligibility within the six month period, you will lose your remaining Credit Bank balance. If you no longer qualify for a self-pay option, COBRA eligibility would still continue.

4. If you are inactive, unused Contribution Credits that you have accumulated in the Contribution Credit Bank will be used to pay for coverage at your selected Plan Level. When you do not have enough credits to pay for your selected Plan Level you and your dependents will become ineligible. Any credit balance left once you become ineligible may be carried forward for a maximum of six (6) months.

Note: Contribution Credits and the Contribution Credit Bank may only be used in connection with the benefits provided by the Southern California Painting & Drywall Industries Health & Welfare Trust Fund and have no other value. If your employer contributes a fixed amount per month, you will be assigned to

the maximum Plan level that is appropriate for that contribution. You will not qualify for the Reserved Contribution Credits program except to the extent you have a frozen credit bank for prior work as a bargaining employee.

CONTINUATION OF COVERAGE

If you are an Active member who has hourly contributions paid on your behalf by a signatory employer, and you have met the standards for initial qualification and are eligible for coverage, the Self-Pay options may be available to you. These options allow you to maintain coverage when you do not have enough Contribution Credits either through hours worked or existing in your Credit Bank to pay for coverage for the next month. If you do not use the Self-Pay option, your coverage will be terminated unless you elect coverage available by law through COBRA (See COBRA, Section 13, for further details).

If you use the Self-Pay option for a given month, the Contribution Credits you earn from the hours you work that month will be credited to your Contribution Credit Bank.

The following coverage continuation options are available subject to their eligibility requirements.

Full Self-Payment Provisions

If you become ineligible for benefits, you may continue coverage through the Full Self-Payment option for a maximum period of six (6) consecutive months. You will be responsible for paying the full cost of coverage every month for the Plan Level you had when you lost eligibility. The full self-pay amount is due by the 20th day of the month prior to the month of coverage. These months of self-payment shall apply to the number of months of continued coverage allowed under COBRA. For information on current Self-Pay rates, please contact the Trust Fund Office at (800) 752-2394.

The claim reimbursement assignment provisions will continue during the full self-payment period.

Buy-Up Provision

If an eligible employee's work hours drop so that he / she loses eligibility, the employee may qualify for a "Buy-Up." Under this provision, if the employee worked at least 50% of the hours required for monthly eligibility, the employee can buy up the difference between the hours actually worked and the hours required to satisfy the monthly eligibility requirement. The required buy up amount will be the difference between the hours actually worked and the hours required for coverage multiplied by the current contribution rate under the Master Labor Agreement (MLA).

Example: An employee was covered under Plan B but his hours dropped to 60 hours. The required number of hours for Plan B is 120 hours a month. The difference between the hours worked and hours required is 60 hours. You would multiply 60 hours by the MLA contribution rate to calculate the required Buy-Up amount.

Required hours for Plan B	120 hours
Hours actually worked	60 hours
Difference	60 hours

60 hours x $8.05 = $483.00 self-payment

The Buy Up can be used for up to six (6) consecutive months. At the end of the 6-month period the employee can self-pay at a flat monthly amount (no hours offset) for an additional six (6) months (See Full Self-Payment Provisions above). The self-payment with offset of hours must be paid by the 20th day of the month prior to the coverage month. If the employee fails to make a timely self-payment in the amount required, the employee will forfeit his or her rights to these self-payment provisions. The employee and his dependents will lose eligibility and will be offered COBRA. You will again be eligible to use the Buy Up option after you re-establish eligibility as an active employee.

DISABILITY CONTINUATION PROVISIONS

Coverage shall be extended during a total disability which occurred while the Employee was eligible for Health & Welfare benefits for the maximum period of time allowed below but in no event shall such coverage be better than those benefits that the employee was eligible for. (Based upon the hours of employment for which contributions were made on the employee's behalf by Contributing Employers.)

1. **Disease or Injury Resulting From Employment.** The employee and his eligible Dependents shall continue to be covered for up to six (6) consecutive months without the requirement to self-pay provided:

    a. the employee is disabled for a minimum of one month;

    b. the employee shall receive one month of disability extension for each month during which he is disabled for more than one-half the number of days in that month up to a maximum of six (6) consecutive months;

    c. coverage shall not be continued past the date the employee recovers from his disability;

    d. the employee assigns his / her rights to Workers Compensation benefit reimbursement to the Plan for those benefits which are paid by the Plan as a result of an occupational injury. The Plan will have the right to subrogate all paid occupational injury claims against the employee's workers compensation insurer, the employer, or any other third party responsible for the illness or injury.

2. **Disease or Injury Resulting from a Non-Occupational Cause.** The employee and his eligible Dependents shall continue to be covered for up to three (3) consecutive months without the requirement to self-pay provided:

    a. the employee is disabled for a minimum of one month;

    b. the employee shall receive one month of disability extension for each month during which he is disabled for more than one-half the number of days in that month up to a maximum of three (3) months;

    c. coverage shall not be continued past the date the employee recovers from his disability;

d. the employee assigns his / her rights to collect reimbursement for medical expenses of employee / dependent resulting from bodily injury caused by a third party. (See Section 14)

If the employee remains disabled after the date a disability extension ends, he may continue coverage through the Full Self-Payment option for a maximum period of six (6) months (See page 49). These months of self-payment shall apply to the number of months of continued coverage allowed under COBRA. A disabled employee shall be required to provide proof of continued disability in a form acceptable to the Board of Trustees during the period of self-payment. Contact the Trust Fund Office for an application**.**

SECTION 9
DEPENDENT ELIGIBILITY PROVISIONS

For eligibility purposes, "dependent" includes only an Employee's:

1. legal spouse, if not legally separated; and

2. dependent child, (includes a legally adopted child or a child placed in your care in anticipation of adoption where the adoption is being actively pursued, foster child, child for whom the Employee is a legal guardian, a step-child, a child who is the subject of a Qualified Medical Child Support Order under age 26.

3. additionally, while the employee is eligible, coverage shall continue for any child who is incapacitated beyond age 26. Proof of such incapacity and dependency must be furnished within 31 days after reaching the age limit or becoming initially eligible for Plan benefits and annually thereafter. An incapacitated child is one:

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

   b) who has a developmental disability or physical handicap; and

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

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

   While the employee is eligible, coverage shall continue for any child who is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee for support and maintenance. If dependent is older than 26 as of the commencement date of employee's eligibility, the employee must submit a doctor's note that the dependent has been disabled since before his / her 26th birthday.

A dependent does not include any person:

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

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

To determine eligibility, proof is required as follows:

1. dependent lawful spouse - a certified copy of a marriage certificate.

2. natural unmarried children - a certified copy of a birth certificate.

3. stepchildren - submission of a certified copy of certification of marriage and a copy of the Court Order showing that the spouse has legal custody of the child.

4. adopted child - submission of a certified copy of a birth certificate and adoption Decree or court documents reflecting placement for adoption.

5. a child under legal guardianship of the Employee.

6. a child upon submission of a Qualified Medical Child Support Order (QMCSO) that contains the following information:

    a) the name and last known mailing address of the participant and each alternate recipient covered by the Medical Child Support Order

    b) a reasonable description of the type of coverage to be by the plan

    c) the date through which the health benefits are provided

    d) the social security number of the participant and each Alternate Recipient covered by the order.

Date Dependent Becomes Eligible for Coverage

Your Dependent becomes eligible for coverage on the later of:

1. the date you become eligible; or

2. the date the individual meets the qualification as defined under the definition of Dependent.

Application for Dependent Coverage

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

When Dependent Coverage Becomes Effective

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

1. the date you apply for Dependent coverage;

2. the date your coverage becomes effective;

3. the date the person becomes an eligible Dependent.

When Coverage of a Newborn Dependent Becomes Effective

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

Effective Date of Changes in Dependent Coverage

Increases and decreases in the amount of Dependent coverage are effective on the first of the month following the loss of eligibility or increase in the level of coverage under this Plan.

Date Dependent Coverage Ends

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

1. the date this Plan ends;

2. the date you become ineligible;

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

4. the date your coverage ends;

5. the date the person ceases to be a dependent as defined by the Plan;

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

SECTION 10
RETIREE ELIGIBILITY PROVISIONS

THE INDEMNITY PPO PLAN IS AVAILABLE ONLY TO RETIREES WHO WERE COVERED UNDER THE INDEMNITY PPO PLAN WHILE AN ACTIVE PARTICIPANT, UNLESS YOU LIVE OUTSIDE OF AN HMO SERVICE AREA. ALL OTHER RETIREES MUST ENROLL IN AN HMO.

Eligibility Rules for Retirees

A retired member and his eligible dependents shall be eligible for benefits if:

1. he is at least age 50, has not yet reached his 65th birthday, and he was covered under this Plan as an Active Employee for at least 24 of the 36 months immediately before his retirement date. (The term "Active Employee" does not include contributing employers or their employees who are not covered under the terms of a collective bargaining agreement requiring contributions to this Trust) or;

2. he is eligible for a benefit under the Painters International Pension Plan and;

3. he is not eligible for Medicare (this applies to each dependent separately).

Once an eligible Retiree reaches age 65 or becomes eligible for Medicare he may self-pay to continue coverage for his eligible spouse and dependents until the eligible spouse reaches age 65. At that time, coverage for the remaining dependents will terminate and they will be eligible for COBRA benefits.

Enrollment Procedures

If you wish to obtain retiree coverage, you must fully complete the required enrollment form and return it to the Trust Fund Office within 60 days of your retirement or the date which you first become eligible for retiree health coverage, if different. Benefits for a Retiree must begin on the first day of the month following loss of coverage as an Active Participant including COBRA coverage unless extended by HIPAA Special Enrollment Rights. The first self-payment for coverage must be received in a timely manner, and the proper application for coverage must be submitted to the Trust Fund Office.

The Trust Fund Office will send retiree coverage information and the proper enrollment form to each "Active Participant" for whom it has received notice of an upcoming scheduled retirement date.

Premiums for retiree coverage are due in the Trust Fund office no later than the 20th day of the month immediately before the month being covered.

You may enroll your eligible dependents but must do so at the same time you enroll. You may not later add dependents, even if they were not your dependents at the time you enrolled unless your dependents experience a HIPAA qualifying event.

Termination of Coverage

Your coverage will automatically end on the 1st of the month following the month in which the earliest of the following occurs:

1. the date this Plan ends;

2. the date you become ineligible;

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

4. the date you begin active duty in the armed forces, unless the period of military leave is less than thirty-one (31) days;

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

6. 31 days after you have established residence outside the U.S. or Canada;

7. the date Retirees are no longer an eligible class under this Plan;

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

9. the date you return to work in the painting and drywall industry.

Subsequent Return to Active Covered Employment

If you retired and are covered as a Retiree under this Plan and you subsequently return to covered employment, you and your dependents will be eligible for the Active Health Plan on the same terms and conditions as applied to all other Active Employees (you will continue to be eligible as a retiree prior to qualifying for Active Employee Coverage if you meet the other conditions for retiree coverage).

If you are a retiree under age 65 and, after you return to covered employment, you again retire, you shall again become eligible for retiree health coverage for you and your eligible dependents upon your subsequent re-retirement provided you have maintained continuous coverage under the Southern California Painting & Drywall Industries Health & Welfare Trust Fund and meet the rules for retiree coverage in force at that time.

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

1. the date this Plan ends;

2. the date you become ineligible;

3. the first of the month in which your dependent turns age 65 or becomes eligible for Medicare;

4. the date you fail to make a required premium contribution. If you lose eligibility due to non-payment or late payment of premiums, your dependent will not be eligible for reinstatement even if you are subsequently re-hired and covered as an Active Employee and subsequently re-retire prior to when you turn age 65 (although you may still be entitled to regular COBRA Benefits);

5. the date your coverage ends;

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

7. the first of the month following your death; unless you were survived by your spouse on the date of your death. In such event, dependents can stay on the Plan until the spouse reaches age 65;

8. the date the person ceases to be a dependent;

9. the date Dependents are no longer an eligible class under this Plan; or

10. 31 days after the Dependent establishes residence outside the U.S. or Canada.

SECTION 11
EXCLUSIONS AND LIMITATIONS

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

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

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

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

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

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

6. for cosmetic purposes, except for Treatment of:

    a) an injury, which is the result of an accident, with Treatment started by a Physician within 6 months after the accident;

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

    c) reconstructive breast surgery, mastectomy, or lumpectomy, if the surgery resulted from a mastectomy which was caused by disease, illness, or injury.

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

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

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

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

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

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

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

10. hospitalization for dental treatment;

11. in excess of Usual, Customary and Reasonable (UCR) charges, as determined by the Trustees;

12. for Treatment of Temporomandibular Joint (T.M.J.) Dysfunction or Myofascial Pain Dysfunction (M.P.D.), unless such treatment is deemed to be medically necessary;

13. for treatment for non-morbid obesity and weight control, such as:

a) any treatment intended to result in weight loss;

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

14. for the following foot care procedures:

a) trimming of nails, corns and calluses, except with metabolic or peripheral vascular decease;

b) routine hygienic care;

c) services and supplies for fallen arches procedures or flat feet;

15. "Experimental, Investigational, or Educational"; the Trustees use various sources to determine these criteria including but not limited to the Trust's Utilization Review Provider, Medical Consultants, the Health Care Financing Administration and other sources listed in the Definitions Section starting on page 73;

16. for reproductive and sexual disorders and defects, whether or not the consequence of illness, disease, or injury with the exception of erectile dysfunction if medically necessary and prescribed by a physician including, but not limited to:

a) impotency, including implants;
b) frigidity;
c) infertility;
d) reversal of sterilization;
e) artificial insemination;
f) in-vitro fertilization;
g) sex change operations; and
h) genetic testing or counseling;

17. for the following:

a) sexual counseling

b) vocational counseling;
c) outreach; and
d) job training;

18. for “Custodial” or “Maintenance” care;

19. for communications, transportation or travel time, except for ground and air ambulance service, which is allowed for life threatening conditions to the closest facility that is able to provide the required care to treat such life threatening condition;

20 for pre-natal and maternity charges for Dependents other than your covered Dependent spouse.

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

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

23 for expenses incurred as a result of or during the claimant’s commission of a felony;

24. for taxes or surcharges of any kind;

25. Non-emergency services outside of the United States of America.

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

27. for any other services or procedures specifically named in the coverage description section of this SPD.

SECTION 12
COORDINATION OF BENEFITS

The Effect of Another Health Plan on Benefits Under This Agreement:

1. This Plan will coordinate benefits with all other Plans under which a covered person is eligible for benefits and pay up to this Plan's Allowable Expense based on the rules outlined in Item 4 of this Section. In no event will the sum totals paid by this Plan and any other Plan exceed the actual covered billed charges. A "plan" includes group coverage only and does not include an individual policy.

2. Except as provided in Section 3 below, this Plan will reduce its benefits if necessary so that the sum of:

    a) the benefits of this Plan, and

    b) the UNREDUCED benefits of other Plans, do not exceed the total billed charges.

3. Except as provided in Section 4 below, the Plan will reduce its benefits so that the sum of:

    a) the benefits of this Plan; and

    b) the benefits of other plans, do not exceed the total Allowable Expense.

4. The order for benefit determination is:

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

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

    c) If parents are separated or divorced;

        1) If there is a court decree, whereby only one parent is responsible for the health care expenses of the child(ren), the expenses are paid according to the decree.

        2) If there is no decree, the plan of the parent with custody pays first; the (current) spouse of the parent with custody pays second; and the plan of the parent without custody pays last.

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

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

Exchange of Information

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

Payment to Other Plans

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

Recovery

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

SECTION 13
CONTINUATION COVERAGE (COBRA)

You and your dependents may be able to continue eligibility for health care coverage under one of two federal laws which allow a covered person to self-pay the costs of coverage. In 1986 Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA), and in 1994 the Uniformed Services Employment and Reemployment Act (USERRA). These laws require that the covered person be offered the opportunity to self-pay for continued coverage in certain circumstances where coverage would otherwise end. In most circumstances the coverage will cost an amount equal to the Plan's rate for benefits, plus a two percent (2%) administration fee.

The coverage that will be provided to a qualified beneficiary is the same coverage that is provided to other Employees of the employer, unless you choose to purchase only the medical coverage. This will include the right to add Dependents, if already included in the employer's plan. A newly added Dependent such as a newborn or newly adopted child is also a qualified beneficiary.

A person electing to continue coverage under this provision must pay the entire premium to the Trust Fund Office on a monthly basis. Premiums are due on the first day of the month for which coverage is selected. Premiums received within 30 days of that date will be considered timely payment of premium. The initial premium must be paid no later than 45 days after the date of election.

Coverage only provides for the continuation of medical, prescription, dental and vision benefits.

Eligibility For Continuation

An event that causes a loss of coverage is called a "Qualifying Event". Qualifying events for members include:

1. Reduction of hours by employee;

2. Employment ends for any reason other than gross misconduct.

A Dependent is a qualified beneficiary and may also elect to continue the medical coverage if the Dependent's medical coverage terminates because of:

1. Death of the Employee;

2. Termination of the Employee's employment (other than because of gross misconduct) or reduction in the number of hours worked;

3. Divorce or legal separation;

4. The Employee becoming covered under Medicare;

5. A Dependent ceasing to meet the definition of "Dependent";

A qualified beneficiary must elect continuation coverage within 60 days after the later of:

1. The date coverage terminates under this Plan because of the qualifying event; or

2. The date the qualified beneficiary receives notice from the Trust Administrator of the right to this continuation.

COBRA and the provisions for the Right to Self-Pay are integrated to the extent that any continuation coverage provided by the provisions outlined in Section 7 for the right to Self-Pay operates concurrently with continuation coverage provided by COBRA.

Loss of Group Health Plan Coverage

A member enrolled in COBRA will be entitled to enroll the member's spouse or dependent who was not enrolled in COBRA continuation coverage when the member initially enrolled in COBRA for the duration of the member's COBRA coverage if the member's dependent loses coverage under another group health plan and the member's dependent qualifies for special enrollment. The conditions that must be met to qualify for special enrollment are summarized below:

1. At the time member enrolled in the plan, the member's dependent must have been eligible for coverage but was not enrolled in the plan;

2. At the time the member's dependent declined coverage under the plan they must have been covered under another group health plan or had other health insurance;

3. The dependent must be enrolled within 31 days after the termination of their other coverage; and

4. The dependent's loss of coverage under the plan must be for reasons other than the failure to pay a premium or for termination as a result of fraud.

Period of Continuation

Continuation Coverage will terminate on the earliest of the following dates:

1. The end of:

    a) Please refer to Section entitled "Continuation of Coverage under Cal COBRA" on page. Eighteen (18) months in a case where the coverage originally terminated because of termination of employment or reduction in hours, unless CAL-COBRA applies due to coverage through an HMO, in which case COBRA coverage is available for a maximum of thirty-six (36) months except that:

        1) if another qualifying event occurs during the 18 month continuation period, continuation will terminate no later than 36 months after the first qualifying event;

        2) if an employee becomes entitled to 18 months of continuation and then becomes entitled to Medicare coverage before the expiration of the 18 months, the continuation

for qualified beneficiaries (other than the employee) will terminate no later than 36 months from the date the employee originally became entitled to continuation;

3) if a qualified beneficiary is determined to have been disabled under Title II or Title XVI of the Social Security Act at the time of the qualifying event or during the first 60 days of COBRA continuation coverage, the 18 month continuation will be extended to the earlier of 29 months after the qualifying event or the first of the month that begins 30 days after the date of final determination under the Social Security Act that the qualified beneficiary is no longer disabled. This extension will also apply to qualified Dependents of a qualified disabled beneficiary, whether or not those Dependents are disabled. This extension will only apply if the qualified beneficiary has provided notice of such determination within 60 days of such determination and in any event before the end of such 18 months. A qualified beneficiary whose maximum period of continuation is being extended from 18 to 29 months must give notice to the Trust within 30 days after any final determination has been made under the Social Security Act that the qualified beneficiary is no longer disabled. The premium for the 11 month disability extension shall be 150% of the cost of coverage.

b) 36 months, for other qualifying events.

2. After the date of election, the date on which the person first becomes:

a) Covered under any other group health plan (as an Employee or otherwise); or

b) Entitled to benefits under Medicare.

3. The date this Plan ends as to the Participant's Employer. However, employers who withdraw from the plan or are terminated for reasons other than the closing of a business are responsible for providing COBRA continuation coverage to their former members who qualify for COBRA coverage. COBRA coverage will not be provided by the plan under these circumstances.

4. The date the person fails to make a required premium contribution;

5. The date this Plan terminates.

Employer Notification Requirements for COBRA Coverage:

Your employer must notify the Truat Fund Office no later than 31 days after the following qualifying events:

1. Member's death;

2. Member's termination of employment or reduction of hours;

3. Member's entitlement to Medicare;

4. Employer's bankruptcy, if member has retired.

Employee's Notice of Qualifying Event

You or a Qualified Beneficiary or authorized representative must notify the Trust Fund Office no later than 60 days after the date of the following qualifying events:

1. Divorce / legal separation;

2. Dependent child ceases to be a dependent child;

3. Occurrence of a second qualifying event after you or a qualified beneficiary has become entitled to COBRA;

4. Determination by the Social Security Administration that you or a qualified beneficiary is disabled.

If notice is not given in a timely manner, the right to continuation will be lost.

Continuation Period for Retired Members Who Lost Coverage Because of a Former Employer's Bankruptcy:

There is a special continuation period for Qualified Beneficiaries who are retired members and dependents of retired members when the employer declares bankruptcy under Title 11 of the United States Code and the retired member and his / her dependents lose substantial coverage within one year of the date of the bankruptcy proceedings commenced. Coverage will be continued for each qualified beneficiary until the date of that qualified beneficiary's death. However, the surviving eligible spouse or dependent children of a deceased retired member may continue coverage for up to a maximum of 36 months following the retired member's death.

Time Deadlines that affect Right to COBRA Coverage:

1. Qualified beneficiaries will have only 60 days from the date the election notice is received from the contract administrator or the date of loss of coverage, whichever is later, to apply for COBRA continuation coverage;

2. If qualified beneficiaries do not elect COBRA continuation coverage within this 60 day election period, the qualified beneficiaries will not have any group coverage from the plan after the date coverage ends under the plan;

3. Coverage must begin the first day of the month in which full coverage would otherwise terminate. Payment of the first contribution must be received by the Trust Fund Office within 45 days of the date that the Trust Fund Office received notification from the qualified beneficiary that the choice has been made to continue coverage.

4. To enroll, a new dependent (newborn, adopted child, etc.) for COBRA coverage, the contract administrator must be notified within 31 days of acquiring the new dependent. There may be a change in the COBRA premium as a result of the addition of a new dependent.

Termination of COBRA – Coverage under COBRA will end the earliest of the following dates:

1. The first day of the month for which you have not submitted the COBRA premium within the required time period;

2. The date you become covered under another group health plan after you elect COBRA;

3. The first day of the month that you or your qualified beneficiary becomes entitled to Medicare benefits after the election of COBRA coverage;

4. At the end of the last day of the maximum coverage period applicable to the qualified beneficiary;

5. The date on which the plan terminates; or

6. The first day of the month on which your former employer stops making contributions to the plan on behalf of covered employer's active members and provides alternative coverage to its active members under another group health plan.

Extension of COBRA In the Event of Disability:

If you or a family member is entitled to COBRA coverage for 18 months, the 18 month period of coverage can be extended up to an additional 11 months for the qualified beneficiary who is determined to be entitled to Social Security Disability Income Benefits, and for any other qualified beneficiaries if all of the following conditions are met:

The disability occurred on or before the start of the COBRA coverage, or within the first 60 days of COBRA coverage;

The disabled person received a determination of entitlement to Social Security Disability Income Benefits from the Social Security Administration; and

The Trust Fund Office receives a copy of the Social Security Determination prior to the end of the 18 month COBRA continuation period and no later than 60 days after the qualified beneficiary receives the Social Security Determination.

Termination of Extension of COBRA Because of Disability:

COBRA coverage shall terminate at the end of the calendar month following the date that is:

1. Thirty one (31) days after the date the Social Security Administration makes a final determination that the qualified beneficiary is no longer disabled;

2. The first date the disabled individual becomes entitled to Medicare, after electing the COBRA continuation coverage; or

3. The date the maximum 29 month extended coverage period ends.

Continuation Coverage under USERRA

Uniformed Services Employment and Reemployment Act of 1994 (USERRA) was enacted by Congress to provide protections to individuals who are members of the "Uniformed Services." This includes the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or fulltime National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency.

Military Leaves of Absence for Period Less Than 31 Days

USERRA provides that if you are on military leave of absence from your employment, and the period of military leave is less than thirty-one (31) days, you will continue to be eligible for health care coverage under this Plan during the leave with no self-payment required, provided you are eligible for benefits under this Plan at the time your military leave begins**.**

Military Leaves of Absence for Periods More Than 30 Days

1. If you are on a military leave of absence from your employment and the period of military leave is for more than thirty (30) days, USERRA permits you to continue coverage for yourself and your dependents at your own expense at a cost of 102% for up to 24 months, so long as you give your employer advance notice (with certain exceptions) of the leave, and so long as your total leave, when added to any prior periods of leave, does not exceed five (5) years. In addition, dependents may be eligible for coverage under TRICARE formerly CHAMPUS (Civilian Health and Medical Program of the Uniformed Services.)

2. The maximum period of continuation coverage for health care under USERRA is the lesser of (a) twenty-four (24) months after you leave work due to military leave or; (b) the day after the date you fail to timely apply or return to a position of employment with a participating provider.

3. If you continue coverage under USERRA, you will be required to submit any required self-payment to the Trust Fund Office. If you do not elect to continue coverage during your military leave, upon your return to work, your coverage will be reinstated at the same benefit level immediately preceding your service before your leave if you are eligible for re-employment under the criteria established under USERRA.

4. Upon release from active service, your coverage will be reinstated on the day you return to work as if you had not taken leave, provided you are eligible for re-employment under the terms of USERRA and provided you return to work within:

    a) Ninety (90) days from the date of your discharge if the period of service was thirty-one (31) days or more; or

    b) At the beginning of the first full regularly scheduled working period on the first calendar day following your discharge (plus travel time and an additional eight (8) hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescent from an injury caused by active duty, the above time limits are extended for up to two (2) years. A copy of your separation papers must be submitted to the Trust Fund Office to establish your period of service.

5. If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage as provided in the preceding COBRA portion of this SPD. Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the Uniformed Services. The Uniformed Services and the Department of Veterans Affairs will provide care for service connected injuries or illness.

Continuation of Coverage Under Cal-COBRA

Covered persons who have a qualifying event that provides less than thirty-six (36) months of continued coverage and are enrolled in an insured medical plan in the state of California may continue group coverage for up to thirty-six (36) months (including the initial eighteen (18) month period). In order to qualify for this coverage, the covered person must have exhausted his federal COBRA coverage. This coverage, referred to as Cal-COBRA Continuation Coverage, applies only to medical benefits. Under Cal-COBRA Continuation Coverage, premiums for such coverage shall be 110% of the cost of coverage plus administration. Please contact the Trust Fund Office or your HMO for more information.

Right to Convert to Individual Coverage

If a covered person is enrolled in an HMO and the insured medical benefits cease because the covered person is no longer eligible for coverage under the plan, the covered person will be entitled to convert to individual coverage with the medical plan to which the covered person belonged at the time eligibility ceased, without evidence of insurability. Conversion must be applied for within sixty (60) days of the date group coverage ends. HMO subscribers must contact their HMO for more information.

SECTION 14
THIRD PARTY LIABILITY

Reimbursement for Expenses paid as a result of Acts of Third Parties.

If a Participant or Dependent receives benefits from this Trust for an injury or illness sustained from the acts or omissions of any third party, the Trust shall have the right to be reimbursed in the event the Participant or Dependent recovers all or any portion of the benefits paid by the Trust by legal action, settlement, or otherwise, regardless of whether such benefits were paid by this Trust prior to or after the date of any such recovery. The Participant or Dependent will not be entitled to receive any benefits for such expenses under this Trust unless he executes a Subrogation Agreement and agrees in writing to the following conditions:

1. **Reimbursement to Trust**. The Participant or Dependent authorizes reimbursement to the Trust upon obtaining any monetary recovery from any party or organization for such injury or illness, whether by action at law, settlement or otherwise by virtue of executing a Subrogation Agreement, with the understanding that any and all monies recovered as a result of the actions of a third party shall be reimbursed to the Trust in accordance with these provisions.

2. **Assignment of Rights**. The Participant or Dependent irrevocably assigns to the Trust all rights to recover monetary compensation from the third party to the extent of all benefits paid by this Plan and to give notice of this assignment directly to such third parties, their agents or insurance carriers, or to any agent or attorney who may represent the Participant or Dependent. The assignment shall entitle the Trust to reimbursement from any sums to be held or received by the following third parties which are due to the Participant or Dependent prior to any distribution of funds to the Participant or Dependent, and shall provide that such parties shall specifically direct that any and all monies recovered from any third party are to be reimbursed to the Trust in accordance with these provisions. The parties who shall be bound by such assignment are:

    a) any party or its insurance carriers making payments to or on behalf of the Participant or Dependent, including pursuant to any uninsured or under-insured motorist provision of any insurance policy; or,

    b) any agent or attorney receiving payments for or on behalf of the Participant or Dependent.

3. **Notice**. The Participant or Dependent agrees to notify the Trust of any claim or legal action asserted against any third party or any insurance carrier(s) for such injuries or illnesses, as well as the name and address of such third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of the Participant or Dependent or the estate of the Participant or Dependent, or any person claiming a right through such Participant or Dependent, on a form to be supplied by the Trust.

4. **Schedule of Reimbursement**. The Trust shall be reimbursed in accordance with the following schedule based on the net recovery received by the Participant or Dependent from all sources, whether from more than one tortfeasor, under any Worker's Compensation law or otherwise:

Net Recovery	Trust Reimbursement
2 times or more of benefits paid by the Trust	100% of benefits paid
1½ times or more of benefits paid by the Trust	75% of benefits paid
Equal or more of benefits paid by the Trust	66 % of benefits paid
½ or more of benefits paid by the Trust	50% of benefits paid
Less than ½ of benefits paid by the Trust	33 % of benefits paid

a) For the purpose of this Section "net recovery" means the actual amount to be received by the Participant or Dependent from all sources after deducting all attorney's fees and court costs actually incurred.

b) In no event will the Trust's recovery exceed the amount of all proceeds received by the Participant or Dependent from the third party or its insurers.

5. **Subrogation.** The Plan shall have the independent right to bring suit in the name of the Participant or Dependent. The Plan shall also have the right to intervene in any action brought by the Participant or Dependent against any third party, to and including the insurance carrier of the Participant or Dependent under any uninsured or under-insured motorist provision or policy. The Participant or Dependent further agrees to take no action inconsistent with the requirements of this provision.

6. **Cooperation with Trust**. The Participant or Dependent agrees to cooperate fully with the Trustees in the exercise of any Assignment or right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Trust.

7. **Withholding Future Benefits**. The Participant or Dependent agrees to acknowledge that this Trust shall have the Right of Recovery against the Participant or Dependent, should the Participant or Dependent and/or their legal representative fail to execute an Assignment, Subrogation Agreement or any other documents required herein, or fail to reimburse the Trust in accordance with these provisions. In addition, in such event, the Trust may withhold future benefit payments to be made on behalf of the Participant or Dependent until such time as the Trust is fully reimbursed as provided for in this Section.

8. **Disclaimer.** If there is any reasonable cause to believe that the injuries or illnesses sustained by a Participant or Dependent were in any way the result of the acts or omissions of a third party or parties, but the Participant or Dependent disclaims any third party involvement, the Trust shall have the right to require the Participant or Dependent to sign a declaration, under penalty of perjury, regarding such disclaimer as a pre-condition to the payment of any benefits.

9. **Separate Rights**. Each of the provisions set forth above relating to the right of this Trust to receive reimbursement for eligible expenses paid to or on behalf of a Participant or Dependent because of injuries sustained relating to or resulting from the acts and omissions of any third party is separate and any illegality or invalidity of any one provision shall not affect the legality or validity of any other provision.

10. **Medical Expenses Incurred After Settlement or Final Judgment in Third Party Claim**. In the event a Participant or Dependent incurs medical expenses relating to his or her injuries or disabilities which are the subject of a Subrogation Agreement following any settlement or final judgment received from the third party(ies) responsible for the injuries, the Plan shall have no further responsibility to pay for such medical expenses, except as provided below. The Participant or Dependent shall agree to release and hold the Trust harmless from any further obligations under the Subrogation Agreement for any future medical expenses incurred following any settlement or final judgment received from the third party(ies) responsible for the injuries, except as provided below. Provision can be made for the continued payment of such medical expenses under the following circumstances:

    a) Payment by the responsible third party(ies) pursuant to a settlement agreement which is approved by the Fund in writing prior to the execution thereof. In that event, the rights of the Participant or Dependent to the continued payment of medical expenses shall also be assigned to the Trust under the Subrogation Agreement and the Participant or Dependent shall be required to reimburse the Trust for 100% of all medical expenses paid by the Trust under this provision following execution and payment by the responsible third party(ies) under the settlement agreement or final judgment.

    b) At the discretion of the Trustees, payment by the Fund following settlement or final judgment a Participant or Dependent receives from the third party(ies) responsible for the injuries or responsible for reimbursement of the injuries, to the extent that there are no remaining net settlement proceeds to pay for further medical expenses and all third party insurance policy limits have been exhausted, and the Participant or Dependent certifies under penalty of perjury that there are no further sources of third party recovery to pursue.

11. **This Plan does not recognize the Make-Whole Doctrine**. This Plan is entitled to obtain restitution of any amounts owed to it either from third-party funds received by the Participant or the Dependent, regardless of whether the Participant or the Dependent have been made whole for losses sustained as a result of the act of a third party.

12. **This Plan expressly rejects the Common Fund Doctrine with respect to payment of attorney's fees.** A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise this plan's equitable (or other) right to obtain full restitution.

13. **Cooperation with Trust**. The Participant or Dependent, as well as their attorney or agent, shall cooperate fully with the Trustees in the exercise of any Assignment or right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Trust.

14. **Direction to Agent or Attorney**. The Participant or Dependent shall direct that the agent or attorney shall readily comply with the terms of the Subrogation Agreement to reimburse the Trust in accordance with the Reimbursement Schedule as outlined above.

SECTION 15
DEFINITIONS

1. "Plan" means a plan providing benefits or services for or because of medical, dental, prescription, and vision care through:

   a) group or blanket coverage;

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

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

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

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

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

   a) part of a plan coordinates its benefits; and

   b) part does not.

   "Plan" does not mean an individual policy.

2. "Allowable Expense" means an expense which:

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

   b) is Usual Customary and Reasonable (UCR); and

   c) is Medically Necessary; and

   d) in no event shall exceed the lesser of (i) the normal changes billed for that expense by the Provider, or (ii) the contractual rate for such expense under a Preferred Provider Contract between a Provider and this Plan or (iii) the contractual rate for such expense under a Preferred Provider Contract between a Provider and the Plan with which this Plan is coordinating.

3. “Preferred Provider Contract” means a contract under which a health care provider contracts with a health plan or PPO network to provide services at the rates specified in the contract. It does not have to be an exclusive arrangement.

   NOTE: Any expense not payable by another Plan as the primary Plan due to a covered individual’s failure to comply with any Utilization Review or other requirements of that Plan will not be considered an Allowable Expense by this Plan.

4. "Actively At Work" means the Employee:

   a) normally does not work at home;

   b) reports for work on the date in question at the Employee's usual place of work;

   c) upon reporting, can perform all usual and customary duties on a regular basis; and

   d) available for work on Union rolls if covered under a collective bargaining agreement.

   If an Employee does not report to a worksite or normally works at home, the employee is Actively At Work or Available for Work, if, on the date in question, the Employee is neither Hospital confined nor disabled and unable to:

   a) report to a place of work outside of the Employee's home; and

   b) perform all usual and customary duties on a regular basis.

5. "Alternate Recipient" means any child of a Participant who is recognized under an MCSO as having a right to enrollment under the Southern California Painting and Drywall Industry Health and Welfare Trust Fund.

6. California End of Life Option Act – This act allows terminally ill adults who are residents of California, 18 years of age or older, mentally competent and diagnosed with a terminal illness that will, within reasonable medical judgment, lead to death within six (6) months, to legally obtain a prescription medicine or medication from a qualified physician to end their life in a peaceful, humane and dignified manner. For members and dependents eligible for benefits under this Trust, prescription medications issued pursuant to the California End of Life Option Act will be a covered expense through the Trust. In addition, death benefits payable under the Trust will be provided to any eligible Participant who obtains prescription medication pursuant to the provisions of the California End of Life Option Act.

7. "Confined" means that an Employee or Dependent is an inpatient because of an Injury or Sickness in any of the following facilities:

   a) a Hospital;

   b) a Skilled Nursing Facility;

   c) a Rehabilitation Facility;

   d) a Mental or Nervous Facility;

   e) a Substance Abuse Facility ; or

   f) a Hospice Care Facility.

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

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

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

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

   d) enable family members to work outside the home.

   Activities of daily living include such things as:

   a) bathing or dressing;

   b) assistance with mobility; or

   c) feeding or taking oral medicines.

   Such care is Custodial regardless of:

   a) who recommends, provides, or directs care;

   b) where the care is provided; or

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

9. "Durable Medical Equipment" (DME) includes the "basic" models of:

   a) mechanical respirators;

   b) oxygen;

   c) hospital beds;

   d) wheel chairs; and

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

   This does not include such things as, but without limitation, recreation equipment, air conditioners, spas, and exercise equipment even if prescribed by a physician. Nor does it include modifications or maintenance or replacement of vehicles, residences, or other structures.

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

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

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

    a) limited to research or clinical trials;

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

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

    d) of questionable medical effectiveness;

    e) would be considered inappropriate medical treatment; or

    f) "off label" use of specialty and / or prescription drugs.

    To determine whether a procedure is Experimental, Investigational or Educational the Trustees will consider, among other things, opinions of the Trust's Utilization Review Provider, the Trust's Pharmacy Benefit Manager and Medical Consultant, commissioned studies, opinions and references to or by the American Medical Association, CMS, the federal Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies and any other association or program or agency that has the authority to review or regulate medical testing or treatment.

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

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

15. "Incurred" means the date the covered person receives or is furnished the confinement, service or supply for which the charge is made.

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

    a) maintain, rather than improve, a level of physical, ornamental function; or

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

17. “Medically Necessary” means:

a) there is a sickness or injury which requires drugs, therapies, or treatment; and

b) the drugs, therapies or other treatments that are required are appropriate care for the sickness or the injury; and

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

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

3) are not experimental, educational or investigational; and

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

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

a) performed due to definite symptoms of sickness or injury; or

b) they reveal the need for Treatment.

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

19. “Mental Health / Substance Abuse Facility" is:

a) licensed by the state for treatment of drug abuse and alcoholism;

b) accredited by the Joint Commission on Accreditation of Hospitals; or

c) specializes in the treatment of drug addiction and alcoholism and associated disorders and may provide residential treatment, partial hospitalization or outpatient treatment services

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

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

b) spasm and or tenderness of the masticatory muscles;

c) limited jaw movement.

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

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

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

c) dentist (D.D.S.);

d) optometrist (O.D.);

e) podiatrist (D.P.M.);

f) psychologist (Ph.D.);

g) chiropractor (D.C.);

h) physical therapist (P.T.);

i) Marriage Family Child Counselor (M.F.C.C.);

j) Licensed Clinical Social Workers (L.C.S.W.); or

k) Physician's Assistant (P.A.).

This definition does not include someone who is related to a covered person by blood, marriage or adoption or is normally a member of a covered person's household.

22. "Qualified Medical Child Support Order" or "QMCSO" is an MCSO determined by the Trust Fund Office to meet the requirements of a Qualified Child Support Order (QMCSO) and which assigns to an Alternate Recipient the right to receive health benefits under the Plan. A QMCSO may not contain a requirement that the Trust provide any type of benefit or any option not otherwise provided by the plan.

Coverage for Alternate Recipients named in the QMCSO will be granted the first day of the month following the month in which the QMSCO was determined to be qualified. Any payments for benefits made by the Trust pursuant to a QMCSO shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian. You may obtain a copy of the Plan's QMCSO procedures free of charge by request to the Trust Fund Office.

23. "Rehabilitation Facility" is an institution which is:

a) licensed by the state;

b) accredited by the Joint Commission on Accreditation of Hospitals; and

c) accredited by the Commission on Accreditation of Rehabilitation Facilities.

24. "Rehabilitative Care" represents the phase of care following acute inpatient treatment of an illness or injury. It is designed to restore functional capacity that previously existed and was lost due to the

illness or injury. For example, following the inpatient treatment of a stroke or head injury, a rehabilitative program could be developed to include speech and physical therapies.

25. "Schedule" means the Schedule of Coverage.

26. "Service Waiting Period" means a period of continuous, active employment.

27. "Sickness" includes pregnancy.

28. "Skilled Nursing Facility" means a lawfully operated institution that:

    a) provides room and board;

    b) provides daily, 24-hour skilled nursing service:

        1) through one or more professional nurses;

        2) for persons convalescing from Sickness or injury;

    c) is supervised by a Physician or has available the services of a Physician by an established agreement; and

    d) maintains adequate medical records.

    It does not include:

    a) a rest or nursing home;

    b) a place for Custodial or Maintenance care.

29. "Speech Therapy Conditions" are those conditions where Speech Therapy is medically necessary to restore speech that has been lost due to illness or accident.

30. "Temporomandibular Joint Dysfunction (T.M.J.) " is a disorder of the temporomandibular joint which is generally characterized by:

    a) pain or muscle spasms in one or more of the following areas; face, jaw, neck, head, ears, throat, or shoulders;

    b) popping or clicking of the jaw;

    c) limited jaw movement or locking;

    d) malocclusion, overbite or underbite; or

    e) mastication (chewing) difficulties.

31. "Totally Disabled" means:

a) an Employee who cannot perform the usual and customary duties of the Employee's occupation; and

b) a Dependent who cannot carry on any substantial part of the Dependent's normal activities.

32. "Treatment" means the consultations, tests, procedures, medications, and interventions that are:

a) customarily applied in the care of persons with similar complaints and findings by similarly trained practitioners;

b) generally accepted as the effective elements of care.

33. "Usual, Customary and Reasonable" (UCR) charge means one that does not exceed the general level of charges made by others of similar standing:

a) in the locality where the charge is Incurred;

b) when furnishing similar services or supplies;

1) to persons of the same sex and similar age

2) for a similar sickness or injury; and

c) for services or supplies generally considered by medical professionals to provide substantially the same benefits at significantly lower cost.

34. “Protected Health Information (PHI)”

The Privacy Rule defines PHI as health information, no matter what its form – electronic, written or oral, that meets the following criteria:

a) information a Health Plan creates or receives about an individual;

b) information relating to the individual’s past, present or future health condition or past present or future payment for health care services and

c) information that either identifies the individual or creates a basis upon which to identify a person.

SECTION 16
CLAIMS AND APPEALS PROCEDURES

Please see Section 17 for HIPAA requirements.

All claims for benefits under this Plan should be submitted on proper claim form to the Trust Fund Office:

Southern California Painting and Drywall Industries Health and Welfare Trust Fund
P.O. Box 5548
El Monte, CA 91734-1548

You may obtain these forms by contacting the Trust Fund Office at (800) 752-2394.

If possible you should obtain the appropriate forms before the claim is incurred to allow the hospital, doctor or other service provider to fill out in advance the necessary information on the claim form. Charges for hospital confinement, surgical treatment, doctor visits, and dental or vision care must be itemized.

There are certain time limits within which you or your provider must file your claim with the Trust Fund Office or you will lose your coverage under the plan for that claim.

In no event will any claim submitted more than one year from the later of date of service or date expenses are incurred be accepted for payment of benefits under this plan.

The Aetna and Kaiser pre-paid medical plans are fully insured and have their own claims procedures. You should refer to the benefit booklet that describes the specific instructions for filing claims.

Pre-Service Claims (Non-Urgent Care Claim)

A pre-service claim for medical care is a claim that the Plan requires an approval in advance of obtaining medical care. The Plan requires pre-authorizations for non-emergency hospital admissions. If you are scheduled for a hospital stay, your physician should call Managed Care at (800) 274-7767 for pre-admission review.

Additionally, all purchases of Medical supplies and equipment in excess of $1,000 and all rental equipment must be approved in advance by Managed Care Utilization Review Department. Please call (800) 752-2394 for additional information.

You will be notified in writing of the decision no later than 15 days from the date the claim is filed with. This period may be extended for an additional 15 days if prior to the expiration of the initial 15 day period you are notified of the circumstances requiring the extension of time and the date by which expects to render a decision. You and the Trustees may agree to further extensions of these time periods.

Urgent Care Claim

There is no requirement that you obtain pre-approval for an urgent care claim.

Concurrent Care Claims

A concurrent care claim is a claim for continued treatment that has been provided over a period of time or number of treatments which was previously approved but you have been notified that the Plan continuation of treatment will be reduced or terminated. The Plan will not reduce or terminate treatment previously approved as Medically Necessary. Therefore, there can be no concurrent claims.

Post-Service Claims

A post-service claim is a claim for a benefit under the Plan that is not a pre-service claim (e.g., treatment has been rendered or a service performed and you are requesting payment for the treatment or services under that Plan). Post-service claims include requests for actual payment by the Plan of any pre-service claim. If you file a post-service claim, the Trust Fund Office will notify you of its decision within 30 days of the receipt of the claim. The Plan is allowed one 15 day maximum extension if the claim decision cannot be made for reasons beyond the control of the Plan and the Trust Fund Office notifies you prior to the expiration of the initial 30 day period, explains the circumstances for the extension, and identifies the date it expects to render a decision. You and the Trust Fund Office may agree to further extensions of these time periods.

Notice of Claims Denial

If any claim (pre-service or post-service) is denied in whole or in part on the basis of eligibility or that the benefits will not be paid under the Plan because they are not Medically Necessary or not covered, you will be provided with a notice of denial / adverse benefit determination which will contain:

1. The specific reason or reasons for the denial;

2. Reference to the specific Plan provision(s) on which the denial is based;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

4. An explanation of the Appeal Procedures and time limits applicable to such procedures, including a statement of your right to file a civil action under Section 502(a) of ERISA following the exhaustion of the Appeal Procedures (see below);

5. In the case of a denial a statement that:

    a. if an internal rule, guideline, protocol or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol or other criterion will be provided free of charge to you upon request; or

    b. If the denial was based on medical necessity or experimental treatment or similar exclusion or limit then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided to you free of charge upon request.

6. In the case of a pre-service urgent care claim, a description of the expedited appeal review process available for such a claim.

Appeal Procedures

These appeal procedures shall be the exclusive procedures available to any employee or beneficiary who is dissatisfied with an eligibility determination; benefit award or who is otherwise adversely affected by an action of the Trustees. These procedures must be exhausted before you ("Claimant") may file suit under Section 502(a) of ERISA. The Claimant may request an appeal within 180 days of receipt of a claim denial. The Trust Fund Office, as applicable, shall provide access to and copies of documents, records and other information free of charge that are relevant to the claim, upon receipt by the Claimant. Claimant will have the opportunity to submit written comments, documents, records or any other information in support of the appeal.

The appeal will be heard by written submission no later than the Board of Trustees' quarterly meeting that immediately follows the receipt of a request for appeal except if the request for an appeal is filed within 30 days of the date of the meeting. In such a case, an appeal decision will be made no later than the date of the second meeting following the Plan's receipt of the Claimant's request.

If there are special circumstances, the appeal will be heard and decided no later than the third meeting date following the Plan's receipt of the request for an appeal. If such an extension is required, the Claimant will be provided with notice in advance of the extension that will describe the special circumstances and identify the date the appeal will be heard and decided.

Claimant will be notified of all post-service appeal decisions no later than five days after the decision is made. Claimant and the Board of Trustees may agree to further extension of these time periods.

Notice of Appeal Decisions

All appeal decisions, whether adverse or not, will be provided to the Claimant in writing or by electronic notification. If the appeal is denied, in whole or in part, the notification will contain the following information:

1. The specific reason or reasons for the denial;

2. Reference to the specific Plan provision(s) on which the denial is based;

3. A statement that Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant's claim for benefits.

4. A statement of the Claimant's right to bring an action under Section 502(a) of ERISA.

5. In the case of an appeal denial a statement that:
   a. if an internal rule, guideline, protocol or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol or other criterion will be provided free of charge to the Claimant; or

   b. if the denial was based on medical necessity or similar exclusion or limit, then explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided to the Claimant free of charge.

SECTION 17
RIGHTS OF PARTICIPANTS AND BENEFICIARIES

FAMILY MEDICAL LEAVE ACT

If your employer qualifies under the Family Medical Leave Act and makes the appropriate contributions into the Fund, the Plan will provide up to 12 weeks of continued coverage as provided for under the Family Medical Leave.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Fund is required by law to maintain the privacy of protected health information (PHI) maintained by the Fund's health care plans. Please see Section 15 for the definition of PHI.

The Fund must provide participants with notice of its legal duties and privacy practices with respect to protected health information. This Notice of Privacy Practices describes the Fund's privacy practices regarding PHI. Any insurers or HMOs that provide or fund benefits under the Fund should provide you with a separate description of their own privacy practices. Similarly, your personal physician or any other health care provider may have different policies or notices regarding the use and disclosure of the PHI they create or receive.

Your Rights

You have the right to:
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures

We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization

- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information provided in this section.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
  We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
  Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
  Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practice described in this notice and give you a copy of it.
- We will not us or share our information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us now in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date

This Notice is effective March 1, 2015

Jesenia Flores, Privacy Officer
Pacific Southwest Administrators
4399 Santa Anita Ave., Suite 150
El Monte, CA 91731
(800) 752-2394
privacyofficer@pswadmin.com

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

The medical and surgical benefits listed below will be provided (in a manner determined in consultation with the attending physician and the patient) to a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and coverage for physical complications in all stages of mastectomy, including lymphedemas.

If you are enrolled in Kaiser or Aetna, this coverage is subject to plan co-pays and deductibles if any. If you are enrolled in the Indemnity PPO Plan, this coverage is subject to the Plan's annual deductibles and coinsurance provisions.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Federal law prohibits health insurance providers from restricting coverage of hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a Caesarean section unless the mother's or newborn's attending physician, after consulting with the mother, discharges the mother or her newborn less than 48 hours (or 96 hours) after delivery. Accordingly, the Fund may not require a provider to obtain authorization from the Fund for prescribing a hospital stay of not more than 48 hours (or 96 hours).

GENETIC INFORMATION NONDISCRIMINATION ACT

In accordance with Title I of the Genetic Information Nondiscrimination Act of 2008, in no event shall the Plan or any of its insurers discriminate against any Participant on the basis of genetic information with respect to eligibility, premiums and contributions.

HIPAA SPECIAL ENROLLMENT RIGHTS UNDER SCHIP

Effective April 1, 2009, you and your dependents may enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

Also effective April 1, 2009, you and your dependents may also enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or a State Children's Health Insurance Program (SCHIP)**.** However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

STATEMENT OF ERISA RIGHTS

As a participant in the Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Welfare Fund participants will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Trust Fund Office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Trust Fund Office, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Trust Fund Office may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Trust Fund Office to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trust Fund Office. If you have a claim for benefits that is denied or ignored, in whole

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

Assistance with Your Questions

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

The address for the national office is:
U.S. Department of Labor
Employee Benefits and Security Administration
200 Constitution Avenue, NW
Washington, DC 20210

Your regional office is located at:
U.S. Department of Labor
Employee Benefits and Security Administration
Los Angeles Regional Office
1055 E Colorado Boulevard, Suite 200
Pasadena, CA 91106-2341

You may also obtain certain publications about your right and responsibilities under ERISA by calling the publications hotline of the Employee Benefits and Security Administration at (866) 444-3272.

SECTION 18
GENERAL PROVISIONS

LEGAL ACTION

Legal action for recovery on a claim cannot be brought until you have exhausted your administrative appeals and procedures provided by this Plan. Legal action cannot be brought following two years after the time written proof of loss must be furnished.

PHYSICAL EXAMINATION AND AUTOPSY

This Plan may, at its own cost, require physical examinations of the covered person as often as reasonably necessary while a claim is pending. In case of death, this Plan may, at its own cost, require an autopsy where legal.

CLERICAL ERROR

If a clerical error occurs in maintaining the coverage records, premiums will be adjusted. A clerical error will not:

1. continue coverage that should be terminated; nor

2. terminate coverage that should be continued.

WORKERS' COMPENSATION

This Plan does not provide the benefits required by Workers' Compensation or any similar law.

AMENDMENT OR TERMINATION

The Trustees reserve the right to amend or terminate this Plan or any or all parts of it at any. Upon Termination of this Plan, all coverage will immediately terminate, including coverage provided under the Extension of Benefits provision.

DUAL COVERAGE PRECLUDED

No person, other than your spouse, can be covered under this Plan as both an Employee and a Dependent. If a covered person becomes eligible for benefits under this Plan while eligible for similar extended benefits due to a previous period of coverage under this Plan, this Plan will pay the greater benefit, but will not pay both.

OVERPAYMENT

If a benefit is paid under this Plan and it is later shown that a lesser amount should have been paid, this Plan will be entitled to a refund of the excess payment, and will have the right to withhold future benefit payments until reimbursement of the excess payment is made to the Plan, and / or pursue legal and equitable remedies in Court.

GENERAL INFORMATION

Plan Sponsor/Administrator:	The Plan Administrator is the Board of Trustees of the Southern California Painting and Drywall Industries Health and Welfare Trust Fund, a joint board of Trustees composed of an equal number of labor and management trustees. The administration of the Plan is handled through an Administrative Manager who can be contacted at the following address and phone number: Pacific Southwest Administrators 4399 Santa Anita Ave., Suite 150 El Monte, CA 91731 (800) 752-2394
Type of Plan:	Health & Welfare Plan
Plan Website:	www.paintinganddrywalltrustfund.com
Plan Year:	January 1 through December 31
IRS Employer ID Number:	95-1731374
Plan Number:	501
Attorney:	Melissa W. Cook & Associates 3444 Camino Del Rio North, Ste. 106 San Diego, CA 92108
Funding Medium:	Monthly employer contributions are made by each employer and are transmitted to the Trust Department of UBOC, which serves as Fund Custodian for the Trust Fund. Total contributions are held by UBOC in a checking lockbox out of which premium payments are made to the carriers that provide benefits as directed by the Administrator. Funds in excess of those needed for immediate requirement are invested at the direction of Verus on behalf of the Trustees in short-term investments.
Collective Bargaining Agreements:	Contributions to the Plan are made on behalf of each Active Employee in accordance with Collective Bargaining Agreements between the Union and employers in the industry or Non-Bargaining Participation Agreements. The Trust Fund Office will provide you, upon request, with a copy of the applicable Collective Bargaining Agreement. You will be charged 25 cents per page. Additionally, upon written request, the Trust Fund Office will provide you with information on whether a particular employer or employee organization is a sponsor of the Plan and the employer or employee organization's address.

Union:	Southern California Painters and Allied Trades District Council 36 1155 Corporate Center Drive Monterey Park, California 91754
Agent for Service of Legal Process:	Melissa W. Cook 3444 Camino Del Rio North, Ste. 106 San Diego, CA 92108 Legal Process may also be served on any Trustee or the Trust Fund Office.

SECTION 19
CONTACT INFORMATION FOR HEALTH ORGANIZATIONS

These organizations can be reached at the following:

Kaiser Permanente
393 East Walnut Street
Pasadena, CA 91188
1-800-464-4000;
1-800-788-0616 (Spanish)
www.kp.org

Anthem Blue Cross
2029 Century Park East, 6th Floor
Los Angeles, CA 90067
1-800-274-7767
www.bluecrossca.com

Aetna Health of California, Inc.
1385 East Shaw
Fresno, CA. 93710
1-877-647-3776
www.aetna.com

OptumRx
3515 Harbor Boulevard
Costa Mesa, CA 92626
1-800-788-7871
www.optumrx.com

Swiss Reinsurance Corporation
5200 Metcalf Ave.
Overland Park, KS 66201
www.swissre.com

Delta Dental
21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367
1-800-422-4234 (PMI)
1-800-765-6003 (DPO
www.deltadental.com

Pacific Southwest Administrators
4399 Santa Anita Ave, Suite 150
El Monte, CA 91731
1-800-752-2394
www.pswadmin.com