JUNE 2025
BAY AREA AUTOMOTIVE GROUP WELFARE FUND

SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

IMPORTANT NOTICE TO EMPLOYEES, SPOUSES, AND DEPENDENTS

The Board of Trustees of the Bay Area Automotive Group Welfare Fund is pleased to present the health benefit plan outlined in this **Benefits Booklet**. This **Benefits Booklet** summarizes Plan features common to all of the Fund's Plans. The Benefit **Insert** shows the benefits specific to your **Plan**. Because the Plans offered by the Fund are different, the **Inserts** are different, and you should contact the Administrative Office at 1-800-267-3232 if you have any question concerning whether the **Insert** you have received apply to your **Plan** or **Union Agreement**. This **Benefits Booklet** along with a **"Benefit Insert" and the eligibility rules contained in your Collective Bargaining Agreement** constitute the **Summary Plan Description** (SPD) and Plan Document as required by the Employee Retirement Income Security Act of 1974 (ERISA). Note that if you are enrolled in Kaiser HMO coverage instead of the medical benefits described in this Benefits Booklet, you should also receive an *Explanation of Coverage* from Kaiser that is considered part of, and should be kept with, this SPD. If you do not receive an *Explanation of Coverage* from Kaiser, contact the Administrative Office.

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

If you need additional information about your benefits, you may contact the Administrative Office by telephone at 1-800-267-3232. As a convenience to you, the Administrative Office will provide oral answers on the telephone on an informal basis. However, the answers supplied by the Administrative Office are not binding on the Board of Trustees, which has sole discretion to interpret and apply the Plan. Only the Board of Trustees is authorized to interpret the Plan described in this Benefits Booklet and no individual Trustee, Employer or Union representative is authorized to interpret the Plan on behalf of the Board or to act as an agent of the Board.

This document does not serve as a guarantee of continued employment or benefits. The Board of Trustees reserves the right to change, reduce or terminate this or any of the Fund's benefits plans at any time. **The benefit programs and policies described in this Benefits Booklet are current as of June 2025, unless specifically stated otherwise.** From time to time the Administrative Office may mail you notices intended to inform you and your dependents of any changes in benefits. Please read that information carefully and keep it with this Benefits Booklet.

FOREIGN LANGUAGE NOTICE

Para obtener asistencia en Español, llame al **1-800-267-3232**.

如果需要中文的**幫助**, 請撥打這個號碼 **1-800-267-3232.**

This Benefits Booklet contains a summary in English of your rights and benefits under the Bay Area Automotive Group Welfare Fund. If you have any difficulty in understanding any part of this Benefits Booklet, you may contact the Administrative Office at Bay Area Automotive Group Welfare Fund, 4160 Dublin Blvd, Suite 100, Dublin, California 94568 or call 1-800-267-3232.

AVISO EN ESPANOL

Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo Bay Area Automotive Group Welfare Fund. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con Bay Area Automotive Group Welfare Fund, 4160 Dublin Blvd, Suite 100, Dublin, California 94568 o llamar al teléfono 1-800-267-3232.

IMPORTANT TELEPHONE NUMBERS

For information on….	Contact…
General Plan information	Administrative Office 1-800-267-3232
Teamsters Local 665	Local 665 Office 1-415-728-0811
Machinists Local 1101	Local 1101 Office 1-408-440-8716
Anthem Blue Cross Medical Benefits	1-800-274-7767
Kaiser Medical Benefits	Kaiser 1-800-464-4000
Teamsters' Assistance Program (TAP) (alcohol & drug assistance)	1-510-562-3600 1-800-253-8326 (outside SF Bay area)
OptumRx (prescription drugs)	1-800-356-3477 for customer service or mail order 1-855-842-6337 to speak with a pharmacist (mail order prescriptions only)
DeltaCare USA	1-800-422-4234
Bright Now! / Newport Dental	1-800-497-6453
UnitedHealthcare Dental	1-877-816-3596
Vision Service Plan	1-800-877-7195

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ELIGIBILITY, ENROLLMENT AND TERMINATION

In this section you will find information on:

- Earning and keeping your eligibility
- Dependent and domestic partner eligibility
- Annual Open Enrollment
- Special Enrollment
- Termination of coverage
- Continuation of coverage by self-payment

IMPORTANT NOTE ABOUT YOUR COLLECTIVE BARGAINING AGREEMENT

The rules described here are the Plan's generally applicable conditions required to establish and maintain eligibility. Your Collective Bargaining Agreement (or in some cases a Subscriber Agreement) may contain eligibility rules which modify or replace the rules explained below. If you are not sure whether special rules apply to you or whether the Collective Bargaining Agreement which covers your employment is up-to-date you should call the Administrative Office to verify your eligibility rules. **In the event of any conflict between this Benefits Booklet and the Subscriber or Collective Bargaining Agreement, the most recent Subscriber or Collective Bargaining Agreement will control. Contact the Administrative Office immediately if you do not have a copy of the Insert containing the eligibility rules applicable to you.**

ELIGIBILITY RULES

The following are the basic eligibility rules. However, you should consult the Collective Bargaining Agreement for your Employer to determine whether there are any additional eligibility requirements applicable to your Plan.

EMPLOYER CONTRIBUTION

If,

(1) Your Employer is obligated under a Collective Bargaining Agreement accepted by the Fund to make the monthly contribution to the Fund on behalf of employees who have satisfied the waiting period (if any) described in your Collective Bargaining Agreement **and** you have worked the number of hours required under the Collective Bargaining Agreement required for your Employer to make a payment for health & welfare coverage on your behalf, **and**

(2) Your Employer makes the required contribution on your behalf, on time and in full, you will be covered the next month.

BUT PLEASE NOTE

(1) If you are employed by more than one Participating Employer and more than one Employer contributes on your behalf for any one month, your benefits will be no greater than those you would receive if you were employed by only *one* Participating Employer; and

(2) If your Collective Bargaining Agreement is silent on the number of hours you must work in a month for your Employer to be required to make a payment for health & welfare coverage on your behalf, your Employer is required to make a health & welfare payment on your behalf if you worked one day or more in the prior month.

EFFECTIVE DATE OF COVERAGE

Your Collective Bargaining Agreement may specify a **waiting period** before you become eligible for some or all of the benefits described in this Benefits Booklet. To find out whether a waiting period applies to you, check your Collective Bargaining Agreement that came with this Benefits Booklet.

If your Collective Bargaining Agreement **does not** specify a waiting period your coverage will become effective on the first day of the month following the first month of employment in which you worked at least one day in the prior month and your employer has made the required contribution on your behalf.

If your Collective Bargaining Agreement **specifies a waiting period** your eligibility for coverage will become effective on the first day of the month *after* you have satisfied the waiting period and current month's hours requirement.

Example 1. *You start working for a Participating Employer in July and your Collective Bargaining Agreement says,*

(1) your Employer must pay the Plan for your coverage in any month in which you work 96 hours or more and

(2) there is no waiting period in your Collective Bargaining Agreement. – If you work 96 hours or more in July and your Employer makes a timely contribution to the Fund on your behalf, your eligibility for coverage is effective August 1.

Example 2. *You start working for a Participating Employer in July and your Collective Bargaining Agreement says,*

(1) your Employer must pay the Plan for your coverage in any month in which you work 120 hours or more BUT

(2) coverage will not be effective until you have worked at least one day a month for six months for your Employer. – If you are hired in July and

- *work at least one day a month each month July through November; and*
- *work at least 120 hours in December; and*
- *your Employer makes timely payment to the Fund for December hours in January your eligibility for coverage is effective January 1.*

Example 3. *You are hired to work in July and*

(1) your Collective Bargaining Agreement is silent on the number of hours and months needed to establish eligibility and

(2) you work at least one day in July, your employer is obligated to pay the Fund for your August coverage based on July hours and your eligibility for coverage is effective August 1.

ENROLLMENT

Although you may be eligible to participate in the Plan, you will not be covered until the Administrative Office has received your enrollment form. Enrollment forms can be obtained from the Administrative Office as well as from your Union. **To ensure that you begin to receive benefits as soon as you meet the eligibility requirements, you should submit your enrollment form before you have completed the minimum service/hours requirements. There are more details on enrolling later in this section under the heading "Enrolling in the Plan."**

KEEPING YOUR ELIGIBILITY

Employer payments made for hours worked in one month pay for coverage in the following month. Once you have satisfied the initial eligibility requirements and have enrolled in the Plan, you will remain covered from month to month if you work sufficient hours each month and your employer submits the contributions on your behalf to the Fund.

Example 1 *Your Collective Bargaining Agreement requires that if you work 96 hours or more in a month your employer is required to pay the Fund for your health coverage and there is no waiting period for health and welfare eligibility. You are hired in July and in August you work 110 hours. Your employer's timely contribution for August hours makes you eligible for health and welfare coverage in September. However, in September your hours fall below 96 so no payment is made for you based on September hours for October coverage. You will not be covered for October.*

Example 2 *You start working for a Participating Employer in July and your Collective Bargaining Agreement says,*

(1) your Employer must pay the Plan for your coverage in any month in which you work 120 hours or more BUT

(2) coverage will not be effective until you have worked at least one day a month for six months for your Employer – You are hired in July and

- *work at least one day a month each month July through November; and*
- *work at least 120 hours in December; and*
- *your Employer makes timely payment to the Fund in January based on your December hours, your eligibility for coverage is effective January 1; BUT*
- *Your hours fall below 120 in January so no payment is made on your behalf for January hours/February coverage. If in February you work 120 hours or more your coverage will resume in March.*

Your eligibility for benefits depends on the continued and timely payments by your Employer on your behalf. If you do not work enough hours in a month or your Employer fails to pay the Fund for your health coverage when it is due, your eligibility will terminate automatically at the end of the last month for which a payment on your behalf was made.

Eligibility will be restored if and when the employer makes the required contributions.

Example *Your employer makes the payment for May hours late, not until June 25. When the contribution is received, you will be covered retroactive to June1.*

Your eligibility will also continue for a limited period of time while you are *not* working if your Collective Bargaining Agreement or applicable law requires your Employer to make payments on your behalf (for example, if you are on leave due to disability).

DEPENDENT ELIGIBILITY

Coverage for your eligible dependents begins when *your* coverage begins provided that you have included the required information about your dependents in your enrollment form. You must notify the Plan by contacting the Administrative Office within thirty (30) days when you add a new dependent—for example, through birth, marriage, or adoption—or their eligibility may be subject to delay.

You will be required to provide a marriage certificate, domestic partner registration, birth certificate, proof of dependent status, or Qualified Medical Child Support Order ("QMCSO").

DEFINITION OF A DEPENDENT

- Your legal spouse or domestic partner;
- Your unmarried child who is younger than age 26 and not on active duty in the armed forces, including,
    - your biological child;
    - your adopted child, including children "placed for adoption";
    - your step-child;
    - any other child for whom you are the court-ordered legal guardian;
- A child designated as your dependent in a valid Qualified Medical Child Support Order (see below for description and rules);
- Your unmarried child age 26 or older who was a covered dependent and Totally Disabled upon reaching age 19, provided the child lives with you for most of the year and is dependent on you for more than half of his or her support (proof of the ongoing disability will be required).

The definitions of dependent children that appear above also apply to the children of a covered domestic partner. There is no coverage for participants or dependents living outside the United States.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If a Qualified Medical Child Support Order ("QMCSO") issued by a court of competent jurisdiction in a divorce or legal separation proceeding requires you to provide health coverage to a child who is not in your custody, the Fund will conform to the order for each month in which you are eligible for coverage. A medical child support order will not be deemed "qualified" unless it includes all of the following:

- name and last known address of the parent who is covered under the Plan,
- name and last known address of each child to be covered under the Plan,
- period of time the coverage is to be provided.

Medical child support orders should be sent to the Administrative Office. Upon receipt, the Plan Administrator will notify you and give you a copy of the Fund's procedures for determining whether the order is a QMCSO.

With respect to a child named in a QMCSO, if the child is not already covered by the Plan, the date the child qualifies for coverage as your dependent is the date specified in the court order. If you do not enroll your child as required by the QMCSO, the Plan Administrator will enroll the child as soon as you satisfy the Plan's eligibility requirements. You may not terminate health care coverage for the child or children covered by the QMCSO unless you submit written evidence that the QMCSO is no longer in effect. However, even where a QMCSO is in place, coverage of the child will continue month-to-month only if your eligibility as a covered employee continues from month-to-month.

JOINT COVERAGE

When both husband and wife are covered under the Plan as eligible employees: (1) each may cover the other as a dependent spouse; and (2) each may cover their dependent children (subject to "the birthday rule" – which requires that the spouse whose birthday occurs earliest in the year is primary).

DOMESTIC PARTNERS

The Plan covers a domestic partner on the same basis as a lawful spouse and your domestic partner's children on the same basis as stepchildren acquired through marriage. To be covered, a domestic partner must meet the requirements for domestic partnership under California state or applicable municipal law (for example, the domestic partnership requirements applicable to persons who live or work in the City and County of San Francisco) and you must have and provide the Plan with a copy of a current, valid Certificate of Domestic Partnership from the State of California Secretary of State or a municipality in which you live or work. To obtain such a certificate you and your domestic partner must:

- have a common residence,
- agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership,
- not be married or a member of another domestic partnership,
- not be related by blood in a way that would prevent you from being married in California,
- be over 18 years of age,
- be capable of "consenting to the domestic partnership" (in other words be of sufficiently sound mind to be able to knowingly enter into a contract).

After establishing a domestic partnership, you and your domestic partner must notify the Administrative Office when any of the above conditions are no longer satisfied or when the domestic partnership has terminated. If you terminate the domestic partnership, your domestic partner and his or her Dependents lose coverage upon the termination of the domestic partnership. Domestic partners and their children who lose coverage upon termination of the partnership are eligible to elect COBRA continuation coverage on the same terms as would apply to a spouse upon divorce. IF YOU FAIL TO TIMELY ADVISE THE FUND THAT YOUR DOMESTIC PARTNERSHIP HAS ENDED YOU MAY BE RESPONSIBLE FOR ANY CLAIMS PAID BY THE FUND ON BEHALF OF YOUR FORMER DOMESTIC PARTNER.

Enrolling a domestic partner. A domestic partner must be enrolled by the later of (1) the date you become eligible for Fund coverage or (2) the date the individual first qualifies as a dependent. Coverage for your domestic partner may be deferred only if the domestic partner has group health coverage elsewhere. If the domestic partner loses the other coverage, he or she may enroll in this Plan if an application is filed within 30 days after the other coverage is lost. Enrollment must be retroactive to the date coverage under the other plan ended.

TAX CONSEQUENCES OF DOMESTIC PARTNER ELIGIBILITY

According to the requirements of the Internal Revenue Code, if your domestic partner is not your "dependent" for federal income tax purposes, the "fair market value" of the part of the employer's contribution to the Plan made on your behalf which funds the domestic partner coverage is treated as additional taxable income. The Plan calculates the fair market value of the coverage each year. The employer portion of the payroll taxes attributed to this income is paid by the Plan. You will be billed for and must pay the employee portion of the payroll taxes. If you fail to pay the employee portion of payroll taxes attributable to domestic partner coverage, your domestic partner will be disenrolled from the Plan effective immediately and will be barred from re-enrollment for two years.

In addition to the employee portion of payroll taxes, you must include as part of your taxable income and pay income taxes on the fair market value of your domestic partner's and his or her dependents' coverage.

ENROLLING IN THE PLAN

You must complete and file an enrollment form with the Administrative Office whenever you change your address, add or drop dependents. You will need to fill in your address, the names of your eligible dependents, and the name of your beneficiary for your life insurance benefits. Remember to update your enrollment form anytime a change occurs. If you terminate employment and later return to work, you must re-enroll or your coverage will automatically be defaulted to the Self-Funded Plan unless there is no Self-Funded Plan available. Payment of claims will be delayed if you do not keep this information current.

If you are in a Kaiser only Plan you will not be covered until you have signed the Kaiser Arbitration Agreement found on the enrollment form or submitted a Kaiser enrollment form to the Fund.

If your Plan provides for a choice of Kaiser or the Self-Insured Plan you will not be covered until you submit an enrollment form. If you do not make a choice between Kaiser and the Self-Insured Plan, you will be defaulted into the Self-Insured Plan.

The Self-Insured Plan and its Anthem Blue Cross "preferred provider organization" (PPO) Network agreement or Medicare may impose coverage terms that are different than the terms of the Plan described in your Summary Plan Description. If so, the PPO agreement or Medicare rules will control how this Plan will cover, process, and pay the claim. This includes, but is not limited to, applicable time limits for processing claims and requirements regarding prior-authorization and utilization review.

DOCUMENTS REQUIRED TO ENROLL DEPENDENTS

To enroll your spouse, you must furnish a copy of your marriage certificate with the Plan enrollment form. To enroll your domestic partner, you must furnish the Plan with a copy of your Certificate of Domestic Partnership (or like document). To enroll a dependent child, you must furnish a copy of the child's birth certificate. If you divorce or terminate your domestic partnership, your ex-spouse or ex-domestic partner and stepchildren lose coverage upon entry of a final divorce decree or termination of domestic coverage (but see COBRA COVERAGE on page 12 of this Benefits Booklet).

IF YOU DIVORCE OR IF YOU TERMINATE A DOMESTIC PARTNERSHIP, YOU MUST INFORM THE PLAN AND FURNISH A COPY OF THE DIVORCE DECREE (OR TERMINATION DOCUMENT FOR A DOMESTIC PARTNER) WITH THE REVISED ENROLLMENT FORM THAT EXCLUDES YOUR FORMER SPOUSE. IT IS FRAUD TO CONTINUE COVERAGE FOR YOUR EX-SPOUSE OR EX-DOMESTIC PARTNER AFTER YOU DIVORCE.

COVERAGE OPTIONS

When you first become eligible for the Plan, you must select your medical and dental coverage. **(Some Plans do not have a choice of coverage—refer to your Insert to see whether this applies to your Plan.)** Whatever Medical or Dental option you choose will also be the Medical and Dental Plan for any of your covered dependents.

MEDICAL PLAN OPTIONS

Under most of the Fund's Plans you have a choice between the Kaiser Health Plan and a Self-Funded Medical Plan. The election you make applies to your entire family. **If your Plan offers a choice of medical options and you do not make a choice within sixty (60) days the Fund will enroll you in the Self-Funded Medical Plan**. If you want to change coverage, you can switch, but your election will become effective on the first of the month following the month the Fund receives your completed election forms or as soon as administratively possible.

KAISER HEALTH PLAN

If you enroll in the Kaiser Health Plan you are not covered by the Self-Funded Medical Plan benefits described in this Benefits Booklet and your Benefit Insert. For most of the Fund's Plans, enrollment in Kaiser is *optional*. However, for some Plans, Kaiser is the only medical coverage offered (see your Benefit Insert). If you are covered by Kaiser, information prepared by Kaiser, including Kaiser's *Evidence of Coverage*, will be sent to you when you first enroll. *Kaiser's Evidence of Coverage* may be obtained by asking the Administrative Office.

To be covered by the Kaiser Health Plan coverage you must sign the Kaiser Arbitration Agreement on the Bay Area Automotive Group Enrollment Form or complete a separate Kaiser enrollment form and send the form to the Administrative Office. **Do not send this form directly to Kaiser**. You must also notify both the Administrative Office **and** Kaiser directly of any changes in your Dependent's status (for example, you marry, add a child or divorce) within sixty (60) days of the change.

DENTAL COVERAGE OPTIONS

For most Plans, Dental coverage options include the Self-Funded Dental Plan and the following Dental Maintenance Organization (DMO) options:

- Bright Now! / Newport Dental
- DeltaCare USA and
- UnitedHealthcare Dental

Refer to your Benefit Insert to see which plans are available to you. If you have a choice of dental options and do not make a choice, you will be enrolled in the Self-Funded Dental Plan (if it is offered by your Plan). However, if the only Dental options available under your Plan are DMOs, you will not be enrolled and **will not have any dental coverage** until you select one of the DMOs. You are allowed to switch dental coverage subject to the Plan's Open Enrollment.

"ROLLING" OPEN ENROLLMENT

Your Plan has a "rolling" open enrollment period. If you participate in a Plan where you have a choice between Kaiser and the Self-Funded Medical Plan or between dental plans, you may make changes to your medical and dental options once every 12 months after your initial election. Each time you change an option, a new 12-month period begins. Contact the Administrative Office to request the forms to make changes to your medical and/or dental options. If you are enrolled in an HMO medical option and you live outside the HMO service area or the closest network provider is (generally) over 15 miles or 30 minutes away from your home or work address, you may change your medical option outside the one every 12 month period. You may also change your Medical option if you add or lose a dependent.

WHEN COVERAGE ENDS

Unless your coverage is continued under the "Continuation of Coverage" section of the Plan (see pages 10 through 20), your coverage generally will end on the earliest of the following dates:

- the first day of the calendar month following a calendar month during which you failed to work the required number of hours (or the employer failed to pay when you did work the required hours) under your Collective Bargaining Agreement (but see discussion of Family and Medical Leave Act on page 10 for possible exception).
- the date the Plan terminates,
- the date your employer terminates participation in the Plan,
- the date you enter full-time military, naval, or air service, except as shown under Military Service Leave (see page 11),
- with respect only to Self-Funded Medical coverage, the date you become insured under the Kaiser Health Plan (or any other health maintenance organization under contract with the Fund), or
- with respect only to the Self-Funded Dental coverage, the date you become insured under any DMO dental option offered by your Plan.

Your dependent's coverage will remain in force until the date that person no longer qualifies as an eligible dependent (for example, because of divorce or because a dependent has reached age 26), but it will not continue beyond the date your coverage terminates.

MEDICARE

Self-Funded Medical coverage will not terminate when you become eligible for Medicare, but it will be coordinated with the Medicare benefits. See the Coordination of Benefits section of this Benefits Booklet (pages 91 to 95) for an explanation of how coordination works.

CERTIFICATE OF COVERAGE

When you lose medical, dental or vision coverage under the Plan, you may request a Certificate of Creditable Coverage by contacting the Administrative Office. The Certificate will state how long you were continuously covered under the Plan. For more information on this, see "Health Insurance Portability and Accountability Act" on page 20.

IF YOU CLAIM COVERAGE FOR SOMEONE WHO IS NOT ELIGIBLE

If you claim coverage for a dependent or other person who does not meet the Plan's eligibility requirements (for example, for a spouse you have divorced or a domestic partner in a domestic partnership you have dissolved) the Fund reserves the right to take any legally permissible actions to recover any amounts wrongly paid, including taking legal action against you for fraud and/or withholding payment on future claims submitted by you and your eligible dependents. The Fund reserves the right to withhold benefit payments for covered expenses until it has fully recovered the amount paid for expenses incurred by ineligible persons. Anyone who submits a claim for a person who is ineligible for coverage as an employee or dependent should be aware that insurance fraud is a crime subject to criminal prosecution.

THE COST OF COVERAGE

The cost of coverage under your Plan is determined annually by the Board of Trustees and adjustments may be made during the year if the Board determines that experience warrants an adjustment. The Board of Trustees sets a monthly contribution rate designed to cover the cost of Plan benefits and maintain reserves. The Board may, at its sole discretion, set different rates for participants enrolled in the Kaiser and Self-Funded medical and dental options, based on the costs of providing these two types of coverage.

The portion of the monthly contribution rate paid by your employer is determined by the terms of the Collective Bargaining Agreement under which you work. How the difference, if any, between the contribution rate established by the Board and the amount your employer is required to contribute under the bargaining agreement is funded will be determined by your union and employer.

The Board of Trustees may also, but is not required to, adjust benefits in any Plan. For example, if the cost of coverage increases to a level such that the contribution rate needed to pay for it rises above the amount your employer is obligated to pay, the Trustees may elect to adjust the level of benefits to conform to Plan funding.

CONTINUATION OF COVERAGE

In this section you will find information on:

- Continuation of coverage during certain absences such as military and disability leaves
- How you may be able to pay for continuing coverage under the law known as "COBRA" in certain circumstances when your coverage would otherwise end

CONTINUATION OF COVERAGE IF TOTALLY DISABLED

If you are prevented from working because you are totally disabled, the medical, prescription drug, dental, and accidental death and dismemberment coverage provided under your Plan for you and your dependents will be extended for up to three months once during the life of your Collective Bargaining Agreement. The three-month extension period begins on the first day of the month following the last month for which your Employer contributed on your behalf. For this purpose, Totally Disabled means the complete inability due to disease or bodily injury to perform your regular and customary work. In no event will you be considered totally disabled if you are engaged in any gainful occupation. **You must complete the Fund disability form to be eligible for this extension of coverage. All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability.**

Under certain Collective Bargaining Agreements, you may be entitled to an additional three months of coverage after the three months of coverage described above. If so, different requirements may apply; for example, you may only be entitled to additional coverage if your disability is due to an occupational injury. Consult your Collective Bargaining Agreement.

The waiver of premium provision applicable to your life insurance coverage is described in "Disability Extension" found in the section on life insurance coverage beginning on page 64 of this Benefits Booklet.

If you remain unable to work at the end of the continuation period you may purchase COBRA Continuation coverage. This coverage can last as long as 18 months, and in some cases up to 29 months. Please see page 14 of this Benefits Booklet for more information on the COBRA rights of disabled employees.

Extension of Coverage for the Disabling Condition Only: If you remain totally and continuously disabled at the end of your COBRA coverage period, or if you choose not to purchase COBRA coverage, medical claims for your **disabling condition only** will be covered for a maximum of twelve months following the termination of your medical coverage if you are covered under the Self-Funded Medical Plan. **This extension applies to your disabling condition only and does not extend eligibility for any of your other medical care (or other care) or any of your dependents. <u>There is no extension of coverage provision under the Kaiser Health Plan</u>**. Such extended coverage will end on the date your total disability ends or the date you first become covered under any plan providing similar benefits, whichever occurs first.

FAMILY AND MEDICAL LEAVE ACT

Your coverage may be continued during an approved family care or medical leave of absence, as provided under applicable federal or state law.

You may be eligible for up to 12 weeks of unpaid leave of absence under the federal Family and Medical Leave Act ("FMLA") or the California Family Rights Act ("CFRA") to take care of family needs such as:

(1) birth and care of a newborn child, newly adopted child, or a child placed for foster care; or (2) care of an ill parent, spouse, child, or your own serious health condition that makes you unable to perform your job. Generally, to be eligible for FMLA/CFRA leave you must have been employed for at least 12 months at a worksite where your employer has at least 5 employees and have worked at least 1,250 hours during the 12-month period immediately before the start of your leave of absence. Whether you qualify for FMLA/CFRA leave will be determined by your employer and Collective Bargaining Agreement.

If you qualify for leave under the FMLA or CFRA, your (and your dependents') eligibility for coverage continues throughout your leave, provided your employer continues to pay monthly contributions for your coverage (as it is required to do for those who qualify). Coverage will continue until the earliest of:

- The exhaustion of your 12-week (or in some cases 26-week) FMLA/CFRA entitlement;
- The date your employer can show that you would have been laid off and the employment relationship terminated; or
- The date you do not return to work, or you inform your participating employer that you will not return to work.

Because the Family and Medical Leave laws do not apply to all employers or all employees, you may or may not qualify for this leave. Disputes over entitlement to FMLA leave must be resolved between you, your union and your employer.

Once you have exhausted your FMLA leave, you may be eligible for COBRA continuation coverage, as described beginning on page 12.

MILITARY SERVICE LEAVE

If you were covered under the Plan and leave employment for active duty or training, your employer is required to continue to pay for your coverage for up to 31 days. If your military leave continues beyond 31 days, you may continue your coverage under the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA") by paying a monthly premium equal to 102% of the cost of your coverage. Such self-payments may be made for up to 24 months. As long as you continue making monthly payments, your USERRA coverage will end on the *earlier* of:

- The date the 24-month USERRA coverage period is exhausted, beginning on the date your military leave started; or
- The day after the date your military leave ends and you have not applied for or returned to work.

You and your covered dependents must elect this coverage; it is not automatic and the duration of the military leave combined with all of your previous periods of military leave under the same Employer must generally not exceed five years. You can elect USERRA coverage after you have informed the Administrative Office that you are taking military leave. If your USERRA leave ends, you may be able to continue benefits under COBRA Continuation Coverage as described beginning on page 12.

For more information on USERRA rights, contact your Employer.

CONTINUATION OF COVERAGE DURING LABOR DISPUTE

If, because of a labor dispute, you lose coverage because you have stopped working for an employer who is contributing towards the cost of your coverage under a Collective Bargaining Agreement, you may continue your coverage by exercising your COBRA right and paying the required contributions yourself. Refer to the section on COBRA for additional information.

COBRA CONTINUATION COVERAGE

COBRA (the Consolidated Omnibus Budget Reconciliation Act) is a federal law that requires the Fund to provide you and your eligible dependents with the opportunity to continue your health coverage at your expense when your Employer-paid health coverage ends as the result of a "qualifying event." When you purchase COBRA coverage, you can choose between medical and prescription drug coverage only ("core coverage") or medical and prescription drug coverage *plus* dental and vision, which is referred to as "full coverage." Life insurance, AD&D insurance, and the employee short-term disability income benefit (time loss benefit) are not COBRA benefits but you may convert your life insurance coverage to an individual policy as described under *"Conversion Privileges"* on page 65.

If you are enrolled in the Kaiser Health Plan option, you may also be eligible for "Cal-COBRA" under California law, as explained on page 20. You must contact Kaiser and not the Administrative Office regarding continuation coverage under California law.

OTHER HEALTH COVERAGE ALTERNATIVES TO COBRA

Because you must pay a premium each month to have COBRA coverage you might want to consider other potentially less expensive alternatives.

- *Health Insurance Marketplace (Covered California) and/or Medi-Cal* – When you lose employer-paid coverage, you will generally be eligible to purchase coverage through the Health Insurance Marketplace commonly referred to as "Covered California." Based on your family income, you may be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. For more information visit www.coveredca.com. You may be directed to Medi-Cal if the information you provide demonstrates you and your family may qualify, and you may apply through the same website. If you do not live in California year round see your state Health Insurance Marketplace or www.healthcare.gov.
- *Other Group Coverage* – You may qualify for special enrollment under your spouse's or some other group health plan for which you are eligible, even if that other plan does not accept late enrollees. Please see your spouse's or the other group health plan's special enrollment provisions for more information and deadlines, but generally enrollment must be requested within **30 days** of losing coverage under this Plan.

WHO IS ELIGIBLE FOR COBRA COVERAGE

COBRA coverage is offered to:

- you, your spouse, your domestic partner and/or your dependent children who are covered under the Plan on the day before a COBRA qualifying event,
- children born to you or placed for adoption with you during the time you are on COBRA coverage, and
- family members who become eligible to enroll for COBRA coverage due to special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) while you or your dependents are on COBRA coverage.

QUALIFYING EVENTS AND DURATION OF COBRA COVERAGE

You, your spouse or domestic partner and dependent children are eligible for 18 months of COBRA continuation coverage if Plan coverage ends because:

- your employment is terminated,
- you retire, or
- your hours are reduced to a level which results in loss of coverage (this includes periods of lay-off, disability leave, medical leave and plant closure as well as loss of coverage due to a labor dispute).

If you were covered under the disability waiver provision described on page 10 under "Continuation of Coverage If Totally Disabled" your 18-month COBRA period begins when coverage under the disability waiver provision ends.

Your spouse or domestic partner and dependent children are eligible for 36 months of continuation coverage if Plan coverage ends because you divorce or end a domestic partnership or die.

Your dependent children are eligible for 36 months of continuation coverage if their Plan coverage ends because of their age. (See the Plan's dependent age limitations on page 4).

EFFECT OF MEDICARE COVERAGE ON COBRA ELIGIBILITY

If you enrolled in Medicare fewer than 18 months before you became eligible for COBRA continuation coverage due to your termination or reduction of hours, your eligible dependents will be entitled to 36 months of COBRA coverage measured from the date of your Medicare enrollment. For your dependents to be entitled to this 36-month coverage period, you must notify the Administrative Office of your enrollment in Medicare and provide information regarding the date your Medicare coverage became effective.

If you elect COBRA continuation coverage and later become entitled to Medicare Part A or B benefits before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if you are entitled to Medicare Part A or B benefits on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement.

For purposes of COBRA coverage, you are considered "entitled to Medicare" if you are enrolled in Medicare Part A or B because you are receiving Social Security benefits or because you applied for Medicare benefits. **When a plan participant or dependent has elected COBRA Continuation Coverage and is also enrolled (or is eligible to enroll) in Medicare Parts A and B, Medicare is the primary payer and the Plan is the secondary payer for all claims you incur while on COBRA.** This means that Medicare will pay the claim first and the Plan will pay the remaining amount of the claim (if any) up to the Plan limits. If you elect COBRA and are also eligible to enroll in Medicare Parts A and B but choose not to do so, the Plan will pay your claim as if you were enrolled in Medicare Parts A and B. This means the Plan will not pay the full amount of your claim. If you or your beneficiary have elected COBRA coverage (or are thinking of electing COBRA coverage) and are also enrolled, or eligible to enroll in Medicare, please call the Administration Office at 1-800-267-3232 to discuss your options

EXTENSIONS FOR 18-MONTH COBRA COVERAGE PERIODS

The 18-month coverage period may be extended under the following circumstances:

DISABILITY EXTENSION

If you or any of your covered dependent(s) were disabled (as determined by the Social Security Administration) on the date of the qualifying event or at any time during the first 60 days after the date of your COBRA qualifying event, you or your covered dependent(s) may continue coverage under COBRA for up to 29 months (11 months plus on top of the ordinary 18 months of COBRA). However, for months 19 through 29 you pay a higher premium (150% of the total cost).

You or your dependents are responsible for notifying the Administrative Office of the Social Security Administration's determination of disability within 60 days after the loss of coverage or the date of the Social Security Administration's determination (whichever is later) and before the end of the initial 18-month period of COBRA coverage. Newborn and adopted children who are determined to be disabled by the Social Security Administration within the first 60 days of birth or placement for adoption are treated as having been disabled within the first 60 days of COBRA coverage. A copy of the Social Security determination must be sent to the Administrative Office at the address listed on page 16.

If you or your dependents were determined to be disabled before COBRA began, you are still entitled to the 11-month extension of COBRA coverage as long as the determination was still in effect on the first day of COBRA coverage.

If you or your dependents are on extended COBRA coverage because of a disability, you must notify the Administrative Office within 30 days of the date you or your dependent receive the Social Security Administration's determination that you or your dependent is no longer disabled. The disability extension will end on the first day of the month that is more than 30 days after the disability ends. The Administrative Office address is listed on page 16.

SECOND QUALIFYING EVENT EXTENSION

If your dependents are entitled to 18 months of COBRA coverage as a result of your termination of employment or reduction of hours and they later experience a second qualifying event within this 18-month period, coverage may be extended an additional 18 months for a total COBRA coverage period of up to 36 months measured from the initial qualifying event.

The second qualifying event is your death, divorce, termination of domestic partnership or a child losing dependent status after the initial qualifying event. This extension does not apply to you, but only to your dependent(s) affected by the second qualifying event. See also "Your Duty To Notify the Plan of a Qualifying Event" on the next page for further information regarding your COBRA notice obligations.

RETIREE'S COBRA RIGHTS IN THE EVENT OF BANKRUPTCY

Retirees and their eligible dependents who lose all or a substantial portion of their health coverage because the retiree's former Employer is the subject of a federal bankruptcy proceeding are entitled to COBRA continuation coverage until the death of the retiree. If the retiree elects continuation coverage and subsequently dies, surviving dependents may make self-payments for an additional 36 months. COBRA coverage in these circumstances does not terminate in the event the retiree becomes entitled to Medicare benefits.

YOUR DUTY TO NOTIFY THE PLAN OF A QUALIFYING EVENT

If Plan coverage ends because of your death, termination, or reduced hours, you and/or your dependents will receive information on your COBRA coverage rights and an election form (COBRA Notice and Election Form). You and/or your dependents will then have 60 days to elect COBRA coverage.

If Plan coverage ends because you divorce your spouse, terminate a domestic partnership, or a dependent is no longer eligible, you or the covered dependent must notify the Administrative Office within 60 days of the event or the day they will lose coverage, whichever is later. If the Administrative Office is not notified within the 60-day period of the qualifying event, your dependent(s) will lose their right to elect COBRA coverage.

If you or your dependents are disabled on the date of your initial COBRA qualifying event (*e.g.,* termination of employment or reduction of hours) or become disabled within 60 days of your COBRA qualifying event and you want the 11-month COBRA extension (as described above), you must notify the Administrative Office within 60 days after *the later of* the date you receive your Social Security disability determination, the date your employment ends, or the date your hours are reduced. If you or your dependents fail to provide timely notice of the disability determination, you and your dependents will forfeit the right to the 11-month extension.

You must also notify the Administrative Office of your or your dependent's enrollment in Medicare. The Administrative Office address is listed on page 16.

ELECTING COBRA COVERAGE

Within 30 days of receiving timely notice of the occurrence of a qualifying event from you, your dependent, or your employer, the Administrative Office will send a COBRA Notice and Election Form to you, your spouse, domestic partner or dependent explaining his or her COBRA rights. This Notice will be sent to the address of record on file with the Administrative Office. **You and your dependents are responsible for keeping the Administrative Office informed of your current mailing address.**

If you or your dependent provides the Administrative Office with a notice of a qualifying event, second qualifying event or a determination of disability by the Social Security Administration, and the Administrative Office determines that you or your dependent is not entitled to COBRA coverage or extended COBRA coverage, the Administrative Office will send you or your dependent a written explanation of the reasons why you are not entitled to COBRA coverage. This explanation will be sent to you within 45 days of receiving the initial notice of a qualifying event.

If you or your dependents are eligible to elect COBRA Coverage, you and your dependents have 60 days from *the later of* (a) the date of the COBRA Notice and Election Form or (b) the date coverage terminates (including coverage under the disability waiver provisions) to make a written election (using the form attached to the Notice) to continue coverage under COBRA. This election may also be made by a representative acting on your or your dependent's behalf.

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

Remember, if you do not elect COBRA coverage within the 60-day election period and you do not have any other continuation rights, you and your dependents will lose the right to elect COBRA coverage and Plan coverage will end.

When considering whether to elect COBRA coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, other health plans may apply preexisting condition exclusions to you if you have more than a 63-day gap between coverage in this Plan and health coverage in your new plan. COBRA coverage may help you avoid such a gap. Second, under California law you have the right to purchase individual coverage free of preexisting conditions if you have maintained health insurance for the eighteen months previous to purchasing individual health insurance. COBRA coverage may enable you to satisfy this requirement.

Finally, you should take into account that you have special enrollment rights under federal law. You may have the right to request special enrollment in another Group Health Plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event giving rise to your right to elect COBRA coverage. You will also have the same special enrollment right at the end of the maximum duration of continuation coverage available to you.

All forms and notices must be mailed to the Administrative Office at the following address:

Bay Area Automotive Group Welfare Fund
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
1 (800) 267-3232

Or by accessing the Member Portal at www.baag.org

It is extremely important that you inform your employer and the Administrative Office whenever you or any of your dependents have a change of address, so that notices can be sent to the correct address.

WHEN COBRA COVERAGE BEGINS

If you choose COBRA coverage at any time during the 60-day election period, coverage will be retroactive to the date of the qualifying event, unless you waived coverage at any time during the 60-day election period and subsequently revoked your waiver and elected COBRA coverage, in which case your coverage will be retroactive to the date of your election. You may not revoke your waiver and elect COBRA coverage once the 60-day election period has ended.

LEVELS OF COVERAGE

You may elect and pay for one of two levels of COBRA coverage:

- "Core Coverage": Medical and Prescription Drug, or
- "Full Coverage": Medical, Prescription Drug, Dental and Vision

Your COBRA payments will be higher if you elect the option including vision and dental coverage.

If Plan coverage is changed for active employees while you or your dependents are on COBRA coverage, the same changes will apply to you and your dependents.

PAYING FOR COVERAGE

If you elect COBRA continuation coverage, you pay the full cost of coverage for you and your dependents plus a 2% administration fee—in other words, 102% of the cost. If you are disabled and qualify for the COBRA extension, the cost of COBRA continuation coverage for the additional 11 months (from the 19th to the 29th month) will be 150% of the cost. The cost is determined annually by the Board of Trustees.

Your first COBRA payment can be sent with the COBRA election form or sent in separately. If not sent with the COBRA election form, your first COBRA payment will be considered late if not received by the Administrative Office within 45 days of the date you elect COBRA coverage.

The first payment covers the cost of COBRA coverage retroactive to the date your Employer-paid coverage ended. You are responsible for ensuring that the amount of your first payment is enough to cover this entire period and you should contact the Administrative Office to confirm the correct amount of your first payment. If the first payment is not received by the end of the 45-day period described above, COBRA coverage will be canceled retroactively and you must pay any health care expenses incurred during that period.

After you make the first payment, COBRA payments are due on the first of the month and are considered late if they are not received within 30 days of the due date. If any of your COBRA payments are late, your COBRA coverage will end as of the first day of the month for which timely payment was not received.

After your first payment, you will be sent a COBRA bill monthly and all payments should be sent to this address:

Bay Area Automotive Group Welfare Fund
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
1 (800) 267-3232

MEDI-CAL HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

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

- have a Medi-Cal share-of-cost of no more than allowed under HIPP provisions, and
- have a high-cost medical condition for which the average monthly cost of treatment is at least twice your monthly COBRA premium.

In addition, persons unable to work because of disability due to HIV/AIDS may qualify if they have a total monthly income less than a percentage allowed under HIPP provisions of the poverty level established by the federal government.

To enroll in HIPP or to find out more information call (866) 298-8443.

AUTOMATIC COVERAGE FOR DEPENDENTS OF COVERED EMPLOYEES CHOOSING COBRA COVERAGE

If you choose to continue coverage under COBRA, coverage for your spouse, domestic partner and dependents will automatically continue **UNLESS** the spouse or dependent independently declines coverage. However, if you choose **NOT** to continue coverage, your spouse and dependents may still choose (and must pay for) coverage for themselves. For many plans, COBRA premiums are based on a "composite"

rate, which means that if you elect COBRA coverage you pay a family rate that covers you and your dependents. No "individual" rate for COBRA coverage is available for composite rate plans. If your plan has "tiered" coverage, meaning that the cost varies based on the number of dependents covered, an individual (not a composite) COBRA rate is available.

SPECIAL COBRA RIGHTS FOR TRADE DISPLACED EMPLOYEES

If your coverage ends because your Employer shuts down its plant to shift production to another country or because of an increase in imports, you may be eligible for a tax credit for your COBRA payments, provided you qualify for trade adjustment assistance or alternative trade adjustment assistance from the federal government and your state government. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals"). Under the new tax provisions, eligible individuals can take a tax credit on their tax returns of 65% of premiums paid for qualified health insurance, including COBRA coverage. Advance payments of the tax credit may also be available.

If you become eligible to receive trade adjustment assistance within six months of losing medical coverage, you may also be entitled to a second COBRA election period. To obtain this second COBRA election period, you must provide the Administrative Office with a copy of the certificate issued to you by your state workforce agency entitling you to federal trade adjustment assistance. The Administrative Office will then provide you with a COBRA election notice. Your election to continue coverage must be made during the 60-day period that begins on the first day you become eligible for trade adjustment assistance, but no later than six months after you lost Plan medical coverage. If you elect COBRA during this period, COBRA will begin on the first day of the second election period. Your COBRA period, however, will be measured from the date you lost medical coverage. The second election period does not extend the COBRA period available to you.

If you have questions about these special rights, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/benefits.cfm.

WHEN COBRA COVERAGE ENDS

COBRA coverage will end on the earliest of:

- the end of the 18-, 29-, or 36-month period explained above,
- the date a COBRA coverage payment is not received when due,
- the date the Plan is terminated,
- the date your employer withdraws from the Plan (see below),
- the date the person on COBRA coverage first becomes covered, without limitation as to any preexisting condition, by another Group Health Plan (this date may vary for different members of the same family),
- the date the person on COBRA coverage becomes entitled to Medicare benefits, unless you were entitled to Medicare Part A or B benefits on or before the date you made your COBRA election,
- the first day of the month that begins more than 30 days after a disabled person on extended COBRA coverage is no longer disabled,

- the date determined by the Trustees that your coverage will terminate due to fraud or misrepresentation or because you knowingly provided the Plan or the Administrative Office with false material information, including, but not limited to information relating to another person's eligibility for coverage or status as a dependent. The Trustees reserve the right to rescind coverage retroactive to the effective date of coverage.

If COBRA coverage ends before the 18-, 29- or 36-month coverage period, the Administrative Office will provide a notice to the affected individuals as soon as practicable. The notice will explain the reason for the early termination, the date of the termination, and the availability of alternative group or individual coverage, if any.

WITHDRAWAL OF A CONTRIBUTING EMPLOYER IS *NOT* A COBRA QUALIFYING EVENT

You will not be able to continue coverage if you lose eligibility because your employer ceases contributing to the Fund for its active employees.

If you or your dependents elect COBRA continuation coverage and your employer later stops contributing to the Fund, you may continue your coverage under COBRA to the end of your continuation period (i.e., 18, 29 or 36 months). However, if your employer has an existing Plan or establishes a new plan to cover a class of active employees formerly covered under this Plan, your COBRA continuation coverage will be terminated under this Plan since your employer is required to provide COBRA continuation coverage for you and your dependents under its new plan for active employees. COBRA requirements are subject to change according to federal law. Please direct any COBRA eligibility questions to the Administrative Office at 1 (800) 267-3232.

CONVERSION COVERAGE

If you are covered by the Kaiser Health Plan, you may be entitled to convert your group health coverage to individual coverage while on COBRA or within thirty days of the termination of COBRA coverage. The conversion coverage may cost more and provide fewer benefits than your group health coverage. Contact a Customer Service Representative at Kaiser for conversion information. If you have any questions, inquire immediately on termination of your employment or of your coverage. There is no individual conversion plan offered under the Self-Funded Medical Plan.

SPECIAL COVERAGE CONTINUATION RIGHTS IF YOU ARE ENROLLED IN KAISER WHEN YOUR COVERAGE ENDS

STATE CONTINUATION OF COVERAGE RIGHTS

Many states, including California, require insured medical plans and HMOs (including Kaiser) to provide extended health coverage after group coverage ends. Because the Self-Funded Medical Plan is not an insured medical plan it is not subject to these state law requirements and, therefore, provides no state law-based continuation of coverage rights. State law continuation of coverage generally supplements federal COBRA, or provides continuation coverage to those who are ineligible for federal COBRA coverage.

CAL-COBRA EXTENSION OF CONTINUATION COVERAGE BEYOND 18 OR 29 MONTHS OF FEDERAL COBRA

If you are enrolled in the Kaiser Health Plan when your federal COBRA Coverage ends, California law requires that your HMO provide an additional period of continuation coverage, up to a total of 36 months from the date federal COBRA began. To take advantage of this California-mandated right you must be enrolled in the Kaiser Health Plan immediately prior to losing coverage (in other words, you must be enrolled in the Kaiser Health Plan when you experience your COBRA "qualifying event" as described on pages 13 and 14). Your coverage for this "Cal-COBRA" period will be limited to the benefits provided by the Kaiser Health Plan, Vision Service Plan and Dental Maintenance Organizations such as DeltaCare USA, Bright Now! / Newport Dental and UnitedHealthcare Dental. It will not include the Self-Funded Plan medical, prescription drug and dental benefits.

HEALTH COVERAGE PORTABILITY

The Plan does not exclude medical coverage for preexisting conditions. However, if you become eligible for coverage in another plan, you should know that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) places limits on the restrictions your new plan can impose on your coverage for certain medical conditions. A preexisting condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period must be reduced by your prior health coverage, as long as there is no break in coverage between your Plan coverage and coverage in your new Group Health Plan of 63 or more consecutive days.

Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage. If you buy health insurance other than through an employer-sponsored Group Health Plan, a certificate of prior coverage may help you obtain coverage without a preexisting condition exclusion. If you purchase individual health coverage, you must exercise your right to COBRA continuation coverage to the full extent available to take advantage of this Certificate.

If your eligibility ends, a certificate of coverage will automatically be sent to you at your last known address. If you elect COBRA continuation coverage, you will also receive a certificate after COBRA coverage ends. You and your covered dependents may also request a certificate within 24 months of losing coverage. To get a certificate or for additional information, contact the Administrative Office at 1 (800) 267-3232.

SELF-FUNDED MEDICAL PLAN BENEFITS

In this section you will find information on:

- How you and the Fund share the cost of medical expenses
- Covered services and supplies
- Services where pre-authorization is required
- Exclusions from coverage and limitations on benefits
- Important definitions

The text in this section is intended to be used with your Plan Benefit Insert. That Insert contains important information supplementing what is in this Benefits Booklet.

If your medical coverage is provided by the Kaiser HMO, instead of the Self-Funded Medical Plan, then you should refer to your Kaiser Explanation of Coverage (EOC) for additional information. The Kaiser EOC should be provided to you at the same time you receive this Benefit Booklet (if you are enrolled in Kaiser and did not receive an EOC ask the Fund Administrative Office). Keep in mind that the benefits provided by Kaiser are not the same as those provided under the Self-Funded Medical Plan coverage. Kaiser may cover services not covered by the Self-Funded Medical Plan and the Plan may cover services not covered by Kaiser.

This section provides a general description of the different types of Self-Funded Medical Plan benefits available under your Plan and how they work. Don't forget that all types of coverage are not available to all groups. The Benefit Insert for your Plan gives the specifics of the coverage provided for you, and it is important that you keep your Insert with this Benefits Booklet. ***If you lose an Insert call the Fund at 1-800-267-3232 to ask for a replacement.***

OVERVIEW OF SELF-FUNDED MEDICAL PLAN AND COST SHARING

No matter which type of coverage you have, you will be responsible for paying the cost for at least some services out-of-pocket. Your out-of-pocket costs may be in the form of a ***deductible***, a ***copay*** or ***coinsurance*** (in some plans, all of these).

Deductible The amount of covered charges you must pay before the plan pays anything.

Copay A fixed amount paid by you each time you receive certain types of services (for example, $20 for each visit to the doctor's office).

Coinsurance The percentage of the covered charge you must pay under the plan (for example, if the plan pays 80% of the covered charge, the remaining 20% you pay up to your annual out-of-pocket maximum is "coinsurance").

In most plans, there is an annual limit to your out-of-pocket cost called the ***out-of-pocket maximum*****.** Once you or your covered dependent reaches the applicable out-of-pocket annual maximum listed in the Insert, the Plan covers 100% of covered charges/expenses for the remainder of the year. However, any charges that are not covered (for example charges that exceed the Usual Reasonable and Customary charge or charges for services not Medically Necessary) are not subject to this maximum and must be paid by you. Payments you make for non-covered charges DO NOT count towards your annual out-of-pocket maximum.

Under the Self-Funded Medical Plan, you have the option of seeing preferred (PPO) or non-preferred (non-PPO) providers (see Preferred Provider Network below). The advantages of using preferred providers are:

The cost of treatment is generally lower.

Benefits are usually paid at a higher level (i.e. your co-insurance is less) when you use preferred providers.

In many plans, there are separate out-of-pocket maximums for PPO and non-PPO providers. In these plans, the out-of-pocket maximum is lower when you use PPO providers.

By using a preferred provider you are assured that any out-of-pocket cost you do pay counts towards your annual out-of-pocket maximum.

A benefits package will be mailed to you when your coverage begins.

PREFERRED PROVIDER NETWORK

The costs of your medical care will be lower if you use a "preferred provider"—a physician, hospital, laboratory or other health care provider that has contracted with the Plan's preferred provider organization (the Anthem Blue Cross Prudent Buyer network) to provide services at a discounted rate. You help the Fund save money when you use a participating provider. If your doctor participates in the Anthem Blue Cross network, you will not have to do anything when you receive services except present your Anthem Blue Cross ID card. Remember: when you use preferred providers, you receive a discount. So, do not pay your portion of a preferred provider's bill until you receive an *Explanation of Benefits* from the Administrative Office showing what you owe.

If you use a nonparticipating provider the costs will be higher. Also, for most plans, the Fund will pay a lower percentage of the covered charges if you use a nonparticipating provider and your out-of-pocket maximum may be higher. Check your Benefit Insert and compare the differences between "in-network" and "out-of-network benefits."

FINDING AN ANTHEM BLUE CROSS PRUDENT BUYER PARTICIPATING PROVIDER

You can find participating providers online by using the provider finder at www.anthem.com/ca or calling the Administrative Office at 1-800-267-3232.

PRICING COMPARISON TOOL

The Plan's Consolidated Appropriations Act of 2021 online *pricing comparison tool* allows Plan participants and dependents enrolled in the Anthem Blue Cross PPO Plan to compare cost-sharing for specific items and services, including Substance Abuse benefits. You can access the pricing tool by logging into your account at www.anthem.com or downloading the Sydney Health app at www.sydneyhealth.com. The information contained in the pricing tool is also available over the telephone by calling the Administrative Office at (800) 267-3232 and in paper form, upon request.

MANAGING YOUR CARE THROUGH UTILIZATION REVIEW

To help control Plan costs and ensure that you receive the most appropriate care, the Plan has two care management features: "pre-authorization" and "concurrent review" collectively referred to as utilization review.

PRE-AUTHORIZATION

The Plan requires that you get approval in advance for certain services. These requirements are summarized in the following chart.

Summary of Requirements for Pre-Authorization of Medical Benefits

Situation	Requirement
Hospital Admission	Non-emergency admissions must be reviewed and approved in advance by Anthem Blue Cross. If you or a dependent is admitted on an Emergency basis, you must have the hospital contact Anthem Blue Cross as soon as possible. Any days of hospitalization that have not been approved by Anthem Blue Cross will not be covered by the Plan.
Skilled Nursing Facility	Services must be preauthorized by Anthem Blue Cross.
Inpatient Rehab Therapy	Services must be preauthorized by Anthem Blue Cross.
Maternity	Hospital preauthorization is not required for the first 48 hrs. following a normal delivery or 96 hrs. following a C-Section. Longer stays require authorization.
Substance abuse and mental health	See chart on page 37 for guidance.

INPATIENT HOSPITAL CARE

Pre-admission review and authorization is required before all non-emergency hospital admissions. If your physician recommends hospitalization, it is your responsibility to inform him or her of the pre-authorization requirement. ***Any days of hospitalization that are not authorized by Anthem Blue Cross will not be covered by the Plan.***

If hospitalization is for maternity, preauthorization is not required for the first 48 hours following a normal delivery or 96 hours following a cesarean section. Hospital stays that last longer will require authorization.

Anthem Blue Cross performs all pre-admission reviews. The toll-free number for Anthem Blue Cross is 800-274-7767. Pre-authorization is ordinarily provided by telephone and in many cases on the same day as your physician calls.

After you are admitted to the hospital, concurrent review is designed to ensure that each day of your hospital stay is medically necessary. Concurrent review occurs at required intervals. In many cases, the review will confirm that the intended length of care is medically appropriate. However,

if the intended length of a hospital admission does not appear to be medically necessary, an Anthem Blue Cross representative will consult with your physician regarding your treatment plan.

If you or your dependent is admitted to the hospital on an Emergency basis, please have the hospital contact Anthem Blue Cross as soon as possible. It is a good idea to have a family member or friend contact Anthem Blue Cross.

The same pre-admission and concurrent review procedures that apply to inpatient hospital care also apply to skilled nursing home care.

EMERGENCY CARE

In a medical emergency, you should always seek immediate treatment at the nearest medical facility as quickly as possible. There is no reduction in benefits for using a non-preferred provider when being treated for a true medical emergency. Medical emergency means the sudden onset of a medical condition, which, if not treated immediately could result in death or serious impairment to a bodily function (for a complete definition see page 72). The determination as to whether a condition represents an emergency will be based on the medical circumstances rather than the place of treatment or the manner of transportation to treatment: treatment in an emergency room or transportation to a hospital by an ambulance is not determinative of "emergency" status.

OUTPATIENT CARE

Utilization review also applies to certain types of services provided on an outpatient basis such as home health care and chiropractic care (after 20 visits). It is highly recommended that you also contact the Administrative Office whenever your doctor prescribes or recommends any durable medical equipment (hospital bed, wheelchair, walker, etc.) to make sure the equipment is covered. You should also understand that whenever you receive physical, occupational or speech therapy, your doctor or therapist may be asked to furnish treatment notes and other documentation to justify the Medical Necessity of the treatment. If treatment is expected to last more than 20 visits you MUST have your treatment provider contact the Administrative Office to get approval in advance. The 20-visit limitation described above for certain services provided on an outpatient basis does not apply to outpatient mental health or substance abuse treatment (however, outpatient mental health and substance abuse treatment, like all benefits, must be medically necessary to be covered and charges are subject to the Usual, Reasonable and Customary standards described below).

Appealing a Decision

Requests for required pre-authorizations are considered "pre-service claims" (*or "urgent care claims," if a decision needs to be made on an expedited basis*). If you disagree with the decision made on your request for pre-authorization, you may appeal it. See the information on the applicable type of claim in "Filing a Claim for Benefits and Claim and Appeals Procedures."

SPECIAL PROVISIONS REGARDING WOMEN'S HEALTH CARE

Federal law guarantees certain rights to women:

Under the Women's Health and Cancer Rights Act of 1998, all plans that cover mastectomies are also required to cover related reconstructive surgery. Your plan complies with this requirement.

Reconstructive surgery includes both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage is also available for breast prostheses and for the physical complications of mastectomy, including lymphedemas. Charges for these services will be covered medical charges for a covered person who has had a mastectomy.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. The Plan does not require preauthorization for hospitalization of up to 48 hours (for vaginal delivery) or up to 96 hours (in the case of a cesarean). However, federal law permits the mother's or newborn's attending provider, after consulting with the mother, to discharge the mother earlier.

See also "Voluntary Pregnancy Termination" on page 31 and mammography benefits under "Preventive Care Services for All Women" on page 33.

CALENDAR YEAR DEDUCTIBLE

The deductible is an amount you must pay in covered charges/expenses in a calendar year before the plan pays for any claims. Not all claims expenses will count toward satisfaction of the deductible. For example, any charges exceeding "reasonable and customary" charges or for services not covered by the plan *do not count* for purposes of the deductible. Refer to the "Conditions of Payment" below and "Exclusions" section of this Benefits Booklet on page 39 and your Benefit Insert for the amount of your deductible and the types of expenses that do not apply to your deductible.

FAMILY DEDUCTIBLE MAXIMUM

Most Plans have a limit on the total deductible paid by a family. Once this limit is reached, you and all members of your family will have satisfied the deductible requirement for the year, even if one or more members have not met the individual deductible limit. See your Benefit Insert for the amount of the family deductible applicable to your Plan.

CARRYOVER DEDUCTIBLE

If you incur charges during the **last 3 months** of a calendar year that are applied toward satisfying the deductible, those charges will also be applied toward your deductible **for the next calendar year**.

CONDITIONS OF PAYMENT–WHEN BENEFITS WILL BE PAID

For benefits to be paid, the services and supplies for which a charge is being made must be "medically necessary" and the charge must meet the definition of a "covered charge/expense."

MEDICALLY NECESSARY

With respect to each service and supply, the term "medically necessary" means the service or supply meets all of the following tests:

- It is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects and birth defects.
- It is appropriate for the symptoms, consistent with the diagnosis and otherwise in accordance with generally accepted medical practice and professionally recognized standards.
- It is not mainly for the convenience of the covered person or the covered person's physician or other provider.
- It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in a hospital or other facility, this test means that the covered person needs to be confined as an inpatient due to the nature of the services rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through outpatient treatment.

Subject to other limitations, Medically Necessary services are covered so long as they are provided by a licensed Doctor or Allied Health Professional operating within the scope of his or her license. However, the fact that a Physician or other Allied Health Professional may prescribe, order, recommend, or approve a service or supply does not necessarily mean it is Medically Necessary.

The requirement that services and supplies must be medically necessary does not apply to the preventive ("wellness") care that is specifically covered by the self-funded plan and required under the Affordable Care Act.

COVERED CHARGE/EXPENSE

A "covered charge/expense" is a charge that is made for a medically necessary service or supply (with the exception mentioned above for preventive care) that is furnished to a covered person and meets all of the following tests:

- It is prescribed by a licensed doctor or dentist.
- It is medically necessary.
- It is incurred while the patient is covered by the plan. (*A charge is deemed to be "incurred" at the time the service or supply for which the charge is made is rendered or furnished)*.
- It is not excluded by any of the "Not Covered" lists or the "Exclusions from Coverage" in this section or by the Plan's "General Exclusions and Limitations" (contained in this Benefits Booklet).
- It is certified by the Plan's utilization review organization, if necessary, which at the time this Benefits Booklet is published is the Anthem Blue Cross Prudent Buyer Plan.
- It is within Usual, Reasonable and Customary charge limits or, if the service/supply is furnished by a Preferred Provider, it is within the Contract Rate negotiated with that preferred provider.

COVERED CHARGE/EXPENSE LIMITS

The covered charge limits that apply to each service or supply are:

- the reasonable charge for the service or supply,
- the usual, reasonable and customary charge for the service or supply,
- any limit specified in the lists of covered services, and

- contract rates negotiated with preferred providers.

MEDICAL EXPENSES INCURRED OUTSIDE THE U.S.

If you incur medical expenses while traveling outside the U.S. (including hospital expenses), you will be required to pay the bills and submit claims for reimbursement, in accordance with the Plan's rules for submitting out-of-network claims. In addition, all materials relating to your expenses must be translated into English and you must submit proof of payment with your claim. There is no coverage for participants living outside the United States.

COVERED SERVICES AND SUPPLIES

Use of the term "covered services and supplies" in this section assumes that the charges meet the tests discussed under "Conditions of Payment: When Benefits Will Be Paid" above. See your Benefit Insert for specific information on what the plan pays for a particular service or supply for your group. Don't forget that certain services and supplies, while covered by the Plan, may be subject to limits that restrict the number of visits or days covered or the maximum amount the Plan will pay.

This section describes the most *common types of* services and supplies covered by the plan. If you have a question about a service or supply that you don't see here, don't hesitate to contact the Administrative Office at 1-800-267-3232.

HOSPITAL SERVICES AND SUPPLIES

The Plan will pay benefits for days in the hospital certified by Anthem Blue Cross as Medically Necessary. In the case of a non-emergency admission, the stay must be preauthorized. Covered charges are limited to the preferred provider Contract Rate (if in a preferred facility) or to the hospital's charge for semi-private accommodations. When Medically Necessary the Plan will cover hospitalization in an ICU/CCU, definitive care bed or private room. If it is not Medically Necessary for the patient to be placed in an ICU/CCU, definitive care bed or a private room, an allowance for the hospital's highest semi-private room rate or the preferred provider Contract Rate, as appropriate, will apply. You are responsible for the excess because it will not be a Covered Expense.

Pre-admission laboratory tests and x-ray examinations that are prerequisite to hospitalization and are performed on an outpatient basis within 7 days before the covered person is admitted to the hospital for surgery will be paid on the same basis as the hospitalization.

The benefits payable will depend on whether you are admitted to a preferred or non-preferred hospital. Refer to your Benefit Insert for the specific levels and limits of reimbursement.

For some Plans, the amount payable for hospital services for dependents is subject to a maximum. Check your Benefit Insert to see whether such a maximum applies to your Plan.

You should also keep in mind that once you are hospitalized your care is subject to review under the plan's utilization review provisions.

SKILLED NURSING FACILITY CARE

Inpatient care in a skilled nursing facility is covered if the confinement:

- is approved and preauthorized by Anthem Blue Cross as Medically Necessary, and
- follows a confinement as an inpatient at a Hospital.

The Plan does not cover custodial care, which is care that is primarily to assist or maintain the day-to-day activities of a person rather than for treatment of illness or injury.

AMBULANCE

Covered medical charges for professional ambulance service if medically necessary to or from a hospital where treatment is given, up to the maximum shown on your Benefit Insert.

SURGERY AND ANESTHESIA

Covered medical charges are the charges made by a physician or allied health professional for the professional services listed below, up to the maximum shown on your Benefit Insert for all procedures performed during a period of disability:

- surgery, up to any limits described on your Benefit Insert and subject to the "Surgery Guidelines" below, and
- anesthesiology, up to any limits described on your Benefit Insert and subject to the "Surgery Guidelines" below.

If the surgical procedures are performed in the physician's office the Fund will also pay an amount up to the maximum shown on your Benefit Insert for surgical supplies used in connection with the surgery.

If your surgery is being performed on an inpatient basis make sure you go to participating providers at a participating hospital and that your hospitalization has been pre-authorized. If your surgery is performed on an outpatient basis, you should use a participating facility and participating doctors. If a non-preferred anesthesiologist or assistant surgeon is assigned to your surgery, benefits for their charges are paid at the PPO level of benefits.

SURGERY GUIDELINE

If two or more surgical procedures are performed at the same time, covered medical charges are limited to those incurred for the major procedure plus no more than 50% of those incurred for each lesser procedure that adds significant time or complexity to the entire surgical treatment. Otherwise, no allowance will be paid for the lesser procedures.

For Plan purposes "surgery" includes normal follow-up care and the administration of any local, digital block, or topical anesthesia.

The allowance for the assistant surgeon is limited to 20% of the allowance for the primary surgeon.

THE BENEFIT PAID FOR THE ADMINISTRATION OF ANESTHETICS IS SUBJECT TO REDUCTION, IN ACCORDANCE WITH CUSTOMARY PRACTICE, IF PERFORMED BY THE OPERATING OR ASSISTING SURGEON RATHER THAN AN ANESTHESIOLOGIST. COMPLIANCE WITH THE "NO SURPRISES ACT"

As of August 1, 2022, the "No Surprises Act" limits your out-of-pocket costs and protect you against surprise medical bills. What your Plan pays for medical care depends on whether the hospital, ambulatory surgical center, doctor, or urgent care center is in the Anthem Blue Cross PPO Network *or* "out of network" ("out-of-network" claims are also called "non-PPO" claims). You generally must pay more out of pocket for an "out-of-network" provider or facility than a PPO network provider or facility. However, as of August 2022 your out-of-pocket costs for the following types of out-of-network claims can be no greater than if you were treated "in network" and the out-of-network provider cannot "balance bill" you for additional payment:

- Emergency services,
- Services provided by an *out-of-network* doctor or other health care provider at an *in-network* hospital, ambulatory surgical center, or urgent care center, and
- Air ambulance services.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give informed written consent giving up your protections. You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's PPO Network.

If your claim is covered under the No Surprises Act you will generally only need to pay your normal in-network costs (like coinsurance, copayments, and amounts paid towards deductibles). The health care provider and your health Plan are responsible for the total payment amount from the Plan to the provider through an independent dispute resolution process.

If your claims are covered by the No Surprises Act, your Plan must,

- Cover out-of-network emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services provided by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services at an in-network facility toward your deductible and out-of-pocket limit.

CONTINUITY OF CARE

When a provider or contracted facility is removed from the Anthem Blue Cross network, the Plan or Blue Cross will notify participants and eligible dependents who are receiving continuing care for a serious and complex condition from that provider or facility that: (1) the Provider/Facility is no longer part of the Plan's network and (2) the Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the in-network cost sharing and at the same terms that would have applied had the termination not occurred.

For purposes of this section, a serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-

threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time.

If you believe you have been wrongly billed, contact the Administrative Office at 1-800-267-3232 for assistance. Please see page 79 for instructions on how to file an appeal.

AN ADVERSE BENEFIT DETERMINATION RELATED TO AN EMERGENCY SERVICE, NON-EMERGENCY SERVICE PROVIDED BY A NON-NETWORK PROVIDER AT AN IN-NETWORK FACILITY, AND/OR AIR AMBULANCE SERVICES, WHICH IS COVERED UNDER THE NO SURPRISES ACT, MAY BE ELIGIBLE FOR EXTERNAL REVIEW. PLEASE SEE THE EXTERNAL REVIEW PROCEDURES ON PAGE 87 FOR FURTHER INFORMATION.

DOCTOR VISITS

Covered medical charges are the professional services charges made by a physician (up to the maximums shown on your Benefit Insert) for:

- office visits,
- visits in a hospital, or other medical facilities,
- home visits; or
- telemedicine visits through Anthem's "Live Health Online" service or a video or telephone consultation with your doctor.

CHIROPRACTORS AND ACUPUNCTURISTS.

The services of chiropractors and certified acupuncturists are also covered. However, after 20 visits, neither type of treatment is covered unless it has been pre-approved by the Plan's review organization. Contact the Administrative Office at 1 (800) 267-3232 to arrange for pre-authorization.

DIAGNOSTIC X-RAY AND LABORATORY SERVICES

The Plan covers charges made for laboratory tests or x-ray examinations required because of illness or injury up to the maximum benefit shown in your Benefit Insert. Laboratory and x-ray exams ordered for routine, preventive or 'wellness' purposes are covered as required under the Affordable Care Act or in conjunction with well child care. See sections on "Preventive Care" beginning on page 31.

MATERNITY CARE

Subject to the limits shown on your Benefit Insert, the Plan covers obstetrical services for maternity care on the same basis as surgical benefits. Hospital benefits include newborn routine nursery charges during the covered portion of the mother's confinement. These benefits are available only to you or your dependent spouse. Dependent children are not eligible for maternity benefits, but are covered for treatment of a complication of pregnancy.

Hospital preauthorization is not required for the first 48 hours following a normal delivery or 96 hours following a cesarean section; however, maternity-related hospital stays that last longer require authorization.

Remember to submit a new enrollment form for your newborn as soon as possible after the birth.

INFERTILITY SERVICES

Treatment related to infertility is not covered.

VOLUNTARY PREGNANCY TERMINATION

Voluntary termination of pregnancy is covered in the same manner as other outpatient medical procedures.

PREVENTIVE CARE

The Plans cover preventative care as required for "non-grandfathered plans" required by the Affordable Care Act.

PREVENTIVE CARE FOR ALL ADULTS

Your Plan covers the following preventive care services for all adults without cost-sharing **if provided by a PPO provider**:

1. Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol misuse screening and counseling (for more information regarding substance abuse benefits see pages 36-37.
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults 45 to 75
7. Depression screening
8. Diabetes (Type 2) screening for adults 40 to 70 who are overweight or obese
9. Diet counseling for adults at higher risk for chronic disease
10. Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and older, living in a community setting;
11. Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
12. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945 – 1965

13. HIV screening for everyone ages 15 to 65, and other ages at increased risk
14. Immunization vaccines for adults — doses, recommended ages, and recommended populations vary:
    - COVID-19
    - Diphtheria
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus (HPV)
    - Influenza (flu shot)
    - Measles
    - Meningococcal
    - Mpox
    - Mumps
    - Pertussis
    - Pneumococcal
    - RSV (age 75 and older; if at increased risk 60-74)
    - Rubella
    - Tetanus
    - Varicella (Chickenpox)
15. Lung cancer screening for adults 55 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
16. Obesity screening and counseling
17. Sexually transmitted infection (STI) prevention counseling for adults at higher risk
18. Statin preventive medication for adults 40 to 75 at high risk
19. Syphilis screening for adults at higher risk
20. Tobacco Use screening for all adults and cessation interventions for tobacco users
21. Tuberculosis screening for certain adults without symptoms at high risk.

PREVENTIVE CARE SERVICES FOR WOMEN WHO ARE PREGNANT OR MAY BECOME PREGNANT

Your Plan covers the following preventive care services for women who are pregnant or may become pregnant or without cost-sharing **if provided by a PPO provider**:

1. Anemia screening on a routine basis
2. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
3. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). (Certain services such as birth control will be provided through the prescription drug plan.) **Emergency contraception**, including over-the-counter emergency contraception, when prescribed by a physician Folic acid supplements for women who may become pregnant.

4. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
5. Gonorrhea screening for all women at higher risk
6. Hepatitis B screening for pregnant women at their first prenatal visit
7. Preeclampsia prevention and screening for pregnant women with high blood pressure
8. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
9. Syphilis screening
10. Expanded tobacco intervention and counseling for pregnant tobacco users
11. Urinary tract or other infection screening
12. Maternal depression screening for mothers of infants at 1-, 2-, 4-, and 6-month visits
13. RSV immunization between weeks 32-36

PREVENTIVE CARE SERVICES FOR ALL WOMEN

The Plan covers the following preventive care services for all women without cost-sharing **if received from a PPO provider**:

1. Breast cancer genetic test counseling (BRCA) for women at higher risk
2. Breast cancer mammography screenings every 1 to 2 years for women over 40
3. Breast cancer chemoprevention counseling for women at higher risk
4. Cervical cancer screening
    - Pap test (also called a Pap smear) every 3 years for women 21 to 65
    - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who do not want a Pap smear every 3 years
5. Chlamydia infection screening for younger women and other women at higher risk
6. Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have not been previously diagnosed with type 2 diabetes
7. Domestic and interpersonal violence screening and counseling
8. Gonorrhea screening for all women at higher risk
9. HIV screening and counseling for sexually active women
10. Osteoporosis screening for women over age 60 depending on risk factors
11. Rh incompatibility screening follow-up testing for women at higher risk
12. Sexually transmitted infections counseling for sexually active women
13. Syphilis screening for women at increased risk
14. Tobacco use screening and interventions
15. Annual urinary incontinence screening
16. Well-woman visits to get recommended services for women under 65

PREVENTIVE CARE SERVICES FOR CHILDREN

(For this purpose, unless an age limitation is noted below, "children" means anyone meeting the Plan's definition up to age 19):

The Plan covers the following preventive care services for children without cost-sharing **if provided by a PPO provider**:

1. Alcohol, tobacco and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Bilirubin concentration screening for newborns
5. Blood pressure screening for children ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years
6. Blood screening for newborns
7. Cervical dysplasia screening for sexually active females
8. Depression screening for adolescents beginning routinely at age 12
9. Developmental screening for children under age 3
10. Dyslipidemia screening for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish for all infants and children as soon as teeth are present
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns and for children once between 11 and 14, once between 15 and 17 years and once between 18 and 21 years
15. Height, weight and body mass index (BMI) measurements for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
16. Hematocrit or hemoglobin screening for all children
17. Hemoglobinopathies or sickle cell screening for newborns
18. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11 – 17 years.
19. HIV screening for adolescents at higher risk
20. Hypothyroidism screening for newborns
21. Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary:
    - COVID-19
    - Diphtheria, Tetanus, Pertussis (Whooping Cough)
    - Haemophiles influenza type b

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (PVU)
- Inactivated Poliovirus
- Influenza (flu shot)
- Measles
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella (Chickenpox)

22. Iron supplements for children ages 6 to 12 months at risk for anemia
23. Lead screening for children at risk of exposure
24. Medical history for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
25. Obesity screening and counseling
26. Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
27. Phenylketonuria (PKU) screening for newborns
28. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
29. Tuberculin testing for children at higher risk of tuberculosis ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
30. Vision screening for all children
31. Routine examinations including the charge of a physician for the initial pediatric examination of a newborn performed before the child is released from nursery care.

For an updated list of required Preventive Care Benefit see https://www.healthcare.gov/coverage/preventive-care-benefits/

DIABETES TREATMENT AND MANAGEMENT

The Self-Funded Medical Plan covers Medically Necessary equipment, supplies (including instruction on their use) and care for the treatment of diabetes to the extent not covered by the Plan's prescription drug benefit.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND MEDICAL SUPPLIES

The Plan covers medically necessary Durable Medical Equipment, as defined in this Benefits Booklet, that has been prescribed by a physician and approved by the Plan. Note that purchase of Durable Medical Equipment is covered only if it is less expensive (as determined by the Fund) than

rental of the same equipment. **It is recommended that you or your provider contact the Administrative Office for approval before purchasing any equipment.**

The Plan covers the initial placement and medically necessary repair of covered prosthetics. The cost of replacing a prosthetic is not covered, even if the initial prosthetic was not paid for by the Plan.

When prescribed by a physician, the Plan will also cover Medically Necessary charges for casts, splints, surgical dressings, oxygen, blood, blood products and anesthetics, certain braces, cervical collars, and catheters. Many supplies are not covered. Be sure to refer to the list of "Exclusions from Medical Coverage" on page 39 and call the Administrative Office at 1-800-267-3232 before you purchase any supply not on this list.

The Plan will cover orthotic devices that are medically necessary and prescribed as an alternative to surgery. The Plan will pay up to a total of $1,500 for orthotic devices once every five (5) years. The $1,500 limit is not per foot – a maximum of $1,500 per condition will be paid if the orthotics are necessary for one or both feet. Replacement for orthotics that are worn, lost, or stolen are not covered until the five-year period has run.

Refer to your Benefit Insert for the benefits payable.

REHABILITATION THERAPY

The Plan covers rehabilitation therapy, but only for the purpose of restoring function lost as a result of injury or illness. Services received from a registered or licensed physical therapist, speech therapist, cardiac therapist, or occupational therapist are covered. Services of a massage therapist are **not** covered.

Coverage for inpatient rehabilitation therapy is also subject to Plan provisions governing inpatient hospitalization. See your Benefit Insert.

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

The Plan provides mental health and substance abuse benefits. These benefits are summarized on the chart below. The Plan's mental health and substance abuse benefits are intended to comply with federal Mental Health Parity and Addiction Equity Act (MHPAEA) and accompanying regulations. If the information in this Summary Plan Description conflicts with federal regulations affecting the coverage of mental health and substance abuse treatment, the Plan will comply with the applicable regulatory requirements.

The Plan will pay benefits for inpatient treatment certified by Anthem Blue Cross or the Teamsters Assistance Program (TAP) as Medically Necessary. In the case of a non-emergency admission, the stay must be preauthorized and covered charges are limited to the preferred provider Contract Rate (if in a preferred facility) or to the hospital's charge for semi-private accommodations.

Summary of Requirements for Pre-Authorization of Mental Health and Substance Abuse Treatment	
Situation	**Requirement**
Inpatient	Non-emergency hospital admissions must be reviewed and approved in advance by Anthem Blue Cross. If you or a dependent is admitted to a hospital on an Emergency basis, the hospital must contact Anthem Blue Cross as soon as possible. Any days of non-emergency hospitalization that have not been approved by Anthem Blue Cross will not be covered by the Plan. Non-emergency admission to an inpatient substance abuse treatment facility must be reviewed and approved in advance by TAP. If you or a dependent is admitted to a substance abuse treatment facility on an Emergency basis, the facility must contact TAP as soon as possible. Any days of non-emergency treatment at an inpatient substance abuse treatment facility that have not been approved by TAP will not be covered by the Plan.
Skilled Nursing Facility	Services must be preauthorized by Anthem Blue Cross.
Inpatient Rehab Therapy	Services must be preauthorized by TAP.

Teamsters' Assistance Program. All Plans provide for participation in the **Teamsters' Assistance Program (TAP),** which assists members and their eligible dependents with substance abuse.

TAP provides assessment, referral, and follow-up services for alcohol and drug-related problems. When you call TAP, at 510-562-3600 or 1-800-253-8326 (outside the San Francisco Bay Area), a counselor will refer you to a range of services including community resources, outpatient, day treatment, residential or inpatient levels of care. All calls are confidential.

If you are eligible for TAP benefits, pre-admission review and authorization by TAP is required before all non-emergency inpatient substance abuse admissions. Admission to a residential facility outside the TAP network requires that the facility is certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The Plan covers behavioral health residential treatment for adolescents where it is medically necessary to be treated in a highly structured 24-hour a day therapeutic environment when an adolescent cannot be safely or effectively treated in a less intensive setting. This includes "wilderness therapy" (also known as "outdoor behavioral healthcare"), a treatment option for behavioral disorders, substance abuse, and mental health issues in adolescents which involves spending time living outdoors and in therapy with peers. Like any residential treatment facility, wilderness therapy is not covered unless the facility is properly licensed by the state in which it is located AND accredited by either CARF or JCAHO. Certain complimentary alternative treatment – for example, equine (horse) assisted therapy – will not be covered.

Refer to your Benefit Insert to determine the level of TAP benefits available.

TREATMENT OF AUTISM

The Plan covers treatment for Autism Spectrum Disorder (ASD), including Applied Behavior Analysis (ABA) and Applied Behavior Therapy (ABT). Treatment for autism spectrum disorder is covered subject to the same conditions that apply to other kinds of outpatient therapy, including deductibles, co-pays, co-insurance, review for medical necessity, and other medical management.

Please note that if your Autism therapist is not in the Anthem Blue Cross PPO network your out-of-pocket costs will be higher.

HOME HEALTH CARE

The Plan covers charges incurred for Home Health Care Services provided by an approved home health agency, subject to any coinsurance, benefit limitations, and maximums shown in your Benefit Insert. For benefits to be payable:

- the services must be prescribed by a physician and approved by the Plan,
- the services must be performed by or under the supervision of a person who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a hospital.

See the definition of Home Health Care Services in "Definitions" section.

Note that housekeeping services and custodial care are *not* covered as home health care.

For purposes of your Plan, "Home Health Agency" means a public or private agency or organization certified to participate in the Medicare program that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy, in a home-type environment. An agency must (1) be licensed or certified by the appropriate regulatory authority, if such licensing or certification is required; (2) have policies established by a professional group associated with the agency or organization, which includes at least one registered nurse (R.N.) to govern the services provided; (3) provide for full-time supervision of such services by a physician or R.N.; (4) maintain a complete a comprehensive medical record on each patient; and (5) have a full-time administrator.

HOSPICE CARE

If a covered person is terminally ill with a life expectancy of six months or less, the Fund will pay benefits for palliative and supportive medical and nursing services rendered by an approved hospice agency at the rate shown on your Insert.

Benefits are available for both inpatient and home hospice care. Hospice services typically include the following types of services:

- medically necessary professional nursing services (including the services of a home health aide if care is provided at home),
- physical therapy services,
- nutrition counseling and special meals,
- durable medical equipment,

- medical social services for the terminally ill patient and his or her family. Your Plan also covers bereavement counseling for family members during the bereavement period—up to a maximum of 8 sessions during the 12-month period following death.

COMMERCIAL DRIVER'S LICENSE EXAMINATION

For employees only, the physical examination required for a commercial driver's license is covered on the same basis as if the examination were for the treatment of an illness or injury. This coverage extends to participants enrolled in Kaiser. The Self-Funded Medical Plan will reimburse costs charged by Kaiser to participants taking this examination to the extent such costs exceed the normal copayment for an office visit.

NUTRITIONAL THERAPY COUNSELING

The Plan covers nutritional counseling for treatment of a medical, mental health, or substance abuse conditions if medically necessary and provided by a physician, dietitian, or other licensed health care provider who is licensed or registered to provide such counseling or therapy and is acting within the scope of such license or registration.

EXCLUSIONS FROM MEDICAL COVERAGE

No benefits will be paid for or in connection with the following:

1. Any service or supply that is not incurred as the result of a disease or injury or is not medically necessary, or that is shown as not covered under "Covered Services and Supplies" (pages 27 to 39) in this section or the Plan's "General Exclusions and Limitations."
2. Any service or supply that is not prescribed by a physician or other allied health professional who is practicing within the scope of his license.
3. Expenses in connection with artificial insemination, in vitro fertilization, or any form of assisted reproductive technology.
4. Any claim received more than twelve (12) months after the date the claim was incurred.
5. Cosmetic surgery, that is, any procedure performed mainly to improve the appearance of the covered person, unless it is reconstructive surgery following a mastectomy, to repair damage sustained in an accident and the charges are incurred within a reasonable time thereafter, or medically necessary treatment for gender dysphoria subject to applicable utilization management guidelines.
6. Custodial care, regardless of who prescribes or renders such care.
7. Any drugs or medicines, other than those furnished to a covered person who is an inpatient.
8. Environmental equipment.
9. Exercise programs for the treatment of any condition.
10. Experimental or investigative services, procedures or supplies, and services, procedures or supplies that are not recognized as accepted standards of medical practice through established review mechanisms, such as the Federal Drug Administration or the American Medical Association. However, the Plan covers participation in clinical trials subject to

preauthorization. If the Plan authorizes participation in a clinical trial, the Plan will cover routine costs associated with this trial. The Plan's standard benefits will apply to these routine costs, services, and supplies.

11. Routine eye exams, radial keratotomy or any surgical treatment to correct nearsightedness or farsightedness.

12. Eye refractions, orthoptics, glasses, contact lenses, or the fitting of glasses or contact lenses, except for the first pair of glasses or first pair of lenses for use after cataract surgery.

13. Charges for failure to keep a scheduled appointment.

14. Routine foot care such as callus or corn paring, toenail trimming, or for the diagnosis or treatment of weak, strained, unstable, or flat feet or for any tarsalgia, metatarsalgia or bunion (except for operations that involve the exposure of bones, tendons or ligaments).

15. Genetic testing charges, except amniocentesis for mothers over age 35 or where there is documented risk to the fetus.

16. Expenses for care, treatment or supplies furnished by a program or agency funded by the federal, state, county, or municipal government (other than Medicaid or when required for treatment of a non-service connected condition at a treatment Veterans Administration facility).

17. Hearing aids, any examination for hearing aids, or the fitting of hearing aids.

18. Household devices such as heating lamps, heating pads, bed boards.

20. Lifestyle enhancement programs, such as weight loss and smoking cessation programs (except as covered under the heading "Preventative Care" above).

21. Non-emergency hospital weekend admissions when the condition is not actively treated until the following Monday.

22. Services or supplies for which the person has no obligation to pay.

23. Charges incurred in connection with confinement in a nursing home, rest home, convalescent home or a place for the aged, except as covered in the Skilled Nursing Facility or Rehabilitation Therapy sections above.

24. Nutritional supplements, except when required as preventive care under the Affordable Care Act.

25. Orthopedic shoes, other than for children or if permanently attached to a brace.

26. Services or supplies provided prior to the beginning of coverage or after coverage ends.

27. A private hospital room, unless isolation is approved as medically necessary by Anthem Blue Cross.

28. Services or supplies provided by a relative or by a person who regularly resides in the covered person's home.

30. Reversal of surgical sterilization.

31. Any service or supply to diagnose, treat, repair, or replace the teeth, gums, or supporting structure of the teeth, unless it is rendered for surgical removal of impacted teeth, treatment of tumors, or repair of damage to sound natural teeth if the damage is sustained in an accident and the charges are incurred within two years from the date of the accident. "Sound natural tooth" means a tooth that is organic and formed by the natural development of the body (not manufactured), has not been extensively restored, and has not become

extensively decayed or involved in periodontal disease. (Note: see section "Dental Benefits" for information on dental benefits. This exclusion will not exclude benefits for facility or anesthesia charges incurred for a child under age 7 or for a person of any age who is severely disabled or whose health would be at serious risk without the use of general anesthesia).

35. Travel charges and travel accommodations, whether or not recommended by a physician (except for "ambulance charges," including medically necessary air ambulance to the nearest hospital adequate for treatment as defined in covered medical expenses).

36. Expenses in excess of the usual, reasonable and customary charge, or when applicable, the preferred provider Contract Rate, or charges in excess of those that would have been made in the absence of Self-Funded Medical Plan coverage.

37. Expenses related to sickness or injury caused by war, insurrection, international armed conflict or riot.

38. Wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a physician, except that the initial purchase of a wig will be covered following radiation or chemotherapy treatment, subject to the usual, reasonable and customary expense guidelines.

39. Treatment of Treatment of Temporomandibular Joint Dysfunction (TMJ).

HOW TO FILE A CLAIM FOR MEDICAL BENEFITS

Note: *The discussion below applies to "post-service claims"—claims you submit* ***after*** *you have received a service. Requests for required pre-authorization are also considered claims. See "Pre-Authorization" earlier in this section and the section called "Filing a Claim for Benefits and Claim Appeal Procedures" for more information on those types of claims.*

HOSPITAL CLAIMS

If you are admitted to a hospital, either for an overnight stay or on an outpatient basis, show your Anthem Blue Cross identification card to the admitting office.

OTHER MEDICAL CLAIMS

If you use a participating provider, the provider must submit claims for you. Show your Anthem Blue Cross identification card and be sure the provider is aware that claims should be sent to the Fund rather than to Anthem Blue Cross. Your doctor or treatment facility should be sure that any claim includes,

- your name and ID number,
- the patient's name, date of birth, and relationship to you,
- the date of service,
- the CPT codes—the codes for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association or HCPC codes,

- the ICD-10 codes—the diagnosis codes found in the International Classification of Diseases, 10th Edition, Clinical Modification, as maintained and distributed by the U.S. Department of Health and Human Services,
- the billed charges (bills must be itemized with all dates of physician visits shown),
- the number of units (for anesthesia and certain other claims),
- the federal taxpayer identification number (TIN) of the provider,
- the provider's billing name, address, telephone number, and professional degree or license,
- the place service was rendered if different from the billing address,
- the provider's signature,
- if treatment is due to an accident, accident details (you will be required to sign a third-party liability agreement requiring that you reimburse the Plan if you recover damages), and
- information on other insurance coverage, if any, including coverage that may be available to your spouse through his or her employer.

Your completed claim should be mailed to the Fund at the address above.

DEADLINE FOR SUBMISSION

You should submit your claim as soon as possible after services or supplies are received. **Claims received more than twelve (12) months after the date of service will be denied as untimely**.

QUESTIONS?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see "Filing a Claim for Benefits and Claim Appeal Procedures" later in this Benefits Booklet.

PRESCRIPTION DRUG BENEFITS

In this section you will find:

- A quick-reference guide to prescription drug benefits
- Details on how the plan works
- Use of retail pharmacies
- Mail-order service
- Covered prescription drugs
- Exclusions from coverage
- Information on filing claims

The benefits described in this section are available to you only if you are covered under the Self-Funded Medical Plan. ***If you are enrolled in the Kaiser Health Plan your prescription drug benefits are covered by Kaiser.***

The Plan provides benefits for medically necessary drugs you purchase at retail pharmacies or through the Plan's mail-order service. The Fund has contracted with **OptumRx,** a "pharmacy benefits manager," to administer these benefits. The following chart is a quick guide to your benefits. For further details applicable to your Plan, including copays, see your Plan Benefit Insert.

Summary of Prescription Drug Benefits	
Benefits for Covered Drugs	
Participating pharmacies	OptumRx has developed a network of "participating pharmacies" which includes most large chains and many independents. A list is available from OptumRx.
Drug ID card	When you enroll in the Plan, OptumRx will issue a prescription Drug ID Card. This Card must be presented whenever you obtain prescription drugs from a participating pharmacy. Otherwise, coverage may be denied.
Prescription filled at a participating retail pharmacy	At a retail pharmacy you can receive up to a 34-day supply or 100 units (whichever is greater). Check your Benefit Insert for the amount of your copay. What you pay depends on: • your Plan, and • whether it's a brand name or a generic drug (plus, for some Plans, whether you are dispensed a drug on your Plan's formulary). The Plan covers the remaining cost.
Prescription filled at a nonparticipating retail pharmacy	**No** benefits are paid for prescriptions filled at a nonparticipating retail pharmacy unless you are new to the Plan (first eligible within the last 90 days) or are out of the United States of America. Patients are required to use their prescription Drug ID Card at a network pharmacy in order to receive benefits.

Prescription ordered through the Plan's mail order service	You can receive up to a 90-day supply through the mail order service. What you pay depends on: • your Plan, and • whether it is a brand or a generic drug (plus for some Plans, whether it is a drug on your Plan's formulary). The Plan covers the remaining cost. All maintenance medications must be obtained through OptumRx mail order: "maintenance" for this purpose means a prescription going beyond three months.

HOW THE PLAN WORKS

Whether you use a participating retail pharmacy or the mail-order service, you will pay the appropriate copay shown in your Benefit Insert. At a pharmacy, prescriptions can be for up to a 34-day supply or 100 units (whichever is greater). The mail order program will cover up to a 90-day supply.

To be covered prescriptions MUST be purchased at a network pharmacy using your prescription Drug ID Card. Prescriptions purchased without using your ID Card or at a non-network pharmacy are not covered. The only exceptions are: (1) if your eligibility first began less than 90 days before the purchase was made and you are still awaiting your Drug ID Card or (2) you are traveling outside the country**.**

Prescription drug benefits are separate from your medical benefits, so they are not subject to any medical plan deductibles or out-of-pocket maximums. Prescription drugs charges do not count toward any calendar-year limit on amounts you have to pay for your covered medical charges.

(***Note:*** *The benefits described in this section do not apply to prescription drugs furnished to you while you are in the hospital or a skilled nursing facility, which are covered under your medical Plan's hospital benefits*.)

USE OF RETAIL PHARMACIES

PARTICIPATING PHARMACIES

OptumRx has a national network of participating retail pharmacies which includes most chains and many independents. A list of participating pharmacies is available at no cost from OptumRx. You can also call OptumRx (1 800-356-3477) or go online (www.optumrx.com) to find a participating pharmacy. Your share of the cost is limited to your copayment amount. You pay any copayment due at the time of purchase, and that's it, the pharmacy bills the Plan for the remaining cost. To take advantage of these features, each time you have a prescription filled at the pharmacy you must present your OptumRx Drug Identification Card.

If you do not receive an ID card within 90 days of enrolling, contact the Administrative Office immediately at 1 (800) 267-3232.

MAIL ORDER SERVICE

The OptumRx mail order service offers a convenient way to fill prescriptions for drugs you will be taking on a longer-term basis. For a prescription that you will be taking for more than 90 days, use of the mail-order service is mandatory.

The first time you have a prescription filled through the mail-order service, you will be asked to complete a health history profile for the protection of you and your dependents.

Any copayment due can be paid by check or credit card.

When your prescription is sent to you, the package will include a form and envelope for ordering refills. You may also order refills by phone (1 800-356-3477) or online at www.optumrx.com.

COVERED PRESCRIPTION DRUGS

A prescription drug will be covered if it has been approved by the U.S. Food and Drug Administration (FDA) for the medical condition prescribed, is a drug on the OptumRx Formulary and not otherwise excluded by the Plan. The drugs in the following list are examples of drugs typically covered by the Plan.

- pharmaceuticals requiring a written prescription and dispensed by a licensed pharmacist (or by a hospital pharmacy during a period not involving hospital confinement for the treatment of an illness or injury),
- compounded dermatological preparations such as ointments and lotions that must be prepared by a pharmacist according to your physician's prescription,
- prenatal vitamins,
- insulin and diabetic supplies.

For a list of drugs that are **not covered** by the Plan, see the "Exclusions from Prescription Drug Coverage" beginning on page 46. If you have a question regarding whether a particular drug is covered call OptumRx at 1 (800)-356-3477.

NON-FORMULARY DRUGS

All Plans have a "formulary," a list of approved drugs. The drugs on the formulary have been selected by OptumRx for safety, clinical effectiveness, and cost. YOUR OUT OF POCKET COSTS FOR PRESCRITION DRUGS (YOUR COPAYMENT AMOUNT) ARE LOWEST WHEN YOU USE DRUGS ON THE FORMULARY LIST. Consult your Benefit Insert for the difference in benefits between formulary and non-formulary prescriptions.

You can ask for confirmation of whether your prescription is on the formulary applicable to your Plan by calling OptumRx at 1 (800)-356-3477 or go to the OptumRx website (and click on "Resources" and then "Formulary and updates" to review a copy of the formulary. Your Plan's formulary is the "Select" formulary. While not every formulary Drug is listed, the commonly prescribed ones are. **IF YOU ARE TAKING A DRUG THAT IS NOT ON THE LIST, avoid the higher copayment by talking** to your Doctor to find out if one of the formulary Drugs is appropriate for you.

OFF-LABEL DRUGS

A drug that has FDA approval but is prescribed for an indication or at a dosage that is not an accepted "off-label" use will be covered if that drug has been prescribed for the treatment of a life-threatening or chronic and seriously debilitating condition and the drug has been recognized for treatment of that condition by at least one of the following:

- the American Medical Association Drug Evaluations,
- the American Hospital Formulary Service Drug Information,
- the United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional," or
- two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective, unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

In the absence of one or more of the following, the prescription will not be covered.

- If requested by the Fund, a provider who prescribes the drug will be responsible for submission of documentation supporting compliance with these requirements.
- A "life-threatening condition" means either or both of the following: a disease or condition in which the likelihood of death is high unless the course of the disease is interrupted or a disease or condition that has potential fatal outcome, where the end point of clinical intervention is survival.
- A "chronic and seriously debilitating condition" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause long-term morbidity.

EXCLUSIONS FROM PRESCRIPTION DRUG COVERAGE

No prescription drug benefits will be paid for the following:

1. Any prescription or refill not prescribed by a Doctor.
2. Patent or proprietary medicines not requiring a prescription.
3. Infertility medication, medication for the treatment of sexual dysfunction.
4. Drugs or medicines prescribed to primarily improve or otherwise modify the member's external appearance (for example, Average, Rogaine, Renova, Vaniqa, pigmenting products, depigmenting products, etc.).
5. Anorexiants/anti-obesity medication.
6. Dental related products (oral and topical fluoride, Peridex, Periostat, Atridox, etc.).
7. Injectable medications (unless pre-authorized).
8. Medication dispensed by a licensed hospital or facility, nursing home, rest home, sanitarium, etc. (Drugs dispensed by a hospital are covered under the medical plan).
9. Immunization agents, other than vaccines covered under the Affordable Care Act as preventive care.
10. Appliances and other non-drug items (some supplies are covered under the medical plan).

11. Multiple and non-therapeutic vitamins, cosmetics, dietary supplements, or health and beauty aids, other than vitamins or minerals required to be covered under the Affordable Care Act as preventive care.

12. Smoking cessation medication, such as Nicorette gum.

13. Drugs for which reimbursement is provided or paid for by any other group plan or federal, state, county, or municipal government program.

14. Any single filling or refilling of a prescription for drugs, even if taken in accordance with the doctor's directions, in excess of 34 days at a retail pharmacy or 90 days through mail order unless a prior written agreement has been reached with the Fund.

15. Prescription charges due to occupational injuries or due to sickness covered by Workers' Compensation laws or similar legislation.

16. Prescriptions obtained without using your Drug ID card (except for prescriptions filled by newly eligible participants and by participants traveling outside the country, benefits for which will only be paid if the claim is filed within 90 days of the fill date).

17. Drugs not approved by the FDA.

18. Any Drug labeled "Caution: Limited by federal law to investigational use," or similar labeling, or any Experimental Drug, even though a charge is made.

19. Medication available without a prescription (over-the-counter) even if ordered by a physician (unless listed under covered drugs), other than over-the-counter medications covered under the Affordable Care Act as preventive care; and

20. Any charges for drugs prescribed for conditions not covered by the self-funded Medical Plan or excluded under the Plan's "General Exclusions and Limitations."

HOW TO FILE A CLAIM FOR PRESCRIPTION DRUG BENEFITS

You will not need to file a claim for benefits with OptumRx unless your prescription is filled while outside the country or during the first 90 days of eligibility while awaiting your Drug ID card. Obtain a copy of the "Direct Reimbursement" form by calling OptumRx at (1-800-356-3477) or by going to their website www.optumrx.com and requesting the Direct Member Reimbursement form. Or you can submit your claim online by going to www.optumrx.com and clicking on "Information Center," and then selecting "Forms" and then "Claim Forms" and "Online Claim Form: UHG, Medicare, PDP, MAPD, Commercial, PPO, Union and Others."

You will need to submit a completed claim form along with a copy of the itemized pharmacy receipt which includes the patient name, the pharmacy name and address including city and state, date of service, name of medication(s), NDC number(s), strength, quantity, Rx number, physician name and phone number, and cost of the medication. Send claims to the address listed on the form.

If you have any questions about submitting your claim, contact the Administrative Office 1-800-267-3232 or OptumRx at 1-800-797-9791 or go to www.optum.com.

For information on what to do if you disagree with a decision in regard to your prescription drug claim, refer to the Section entitled "Filing A Claim For Benefits And Claim Appeal Procedures" later in this Benefits Booklet.

DENTAL BENEFITS

In this section you will find:

- A quick-reference guide to dental benefits
- Details on how the plan works
- Recommended pre-determination
- Covered services
- Exclusions from coverage
- Information on filing claims

*Most Plans provide for dental coverage. If you do have dental coverage your options generally include a Self-Funded Dental Plan as well as options offered by Dental Maintenance Organizations (DMOs). Some plans, however, only offer DMO options. Consult your Benefit Insert for the options available to you under your Plan. The DMO options and the Self-Funded Dental Plan differ in important respects. Once every 12 months on a "rolling" basis, you can change from one form of dental coverage for which you are eligible to another***.**

DENTAL MAINTENANCE ORGANIZATION OPTIONS: OVERVIEW

The Fund offers dental coverage through the following DMOs: DeltaCare USA, Bright Now! / Newport Dental and UnitedHealthcare Dental. Not all of these options, also referred to as "Prepaid Dental Plans," are available under every Plan and certain Plans provide **no** dental benefits.[*] Consult your Benefit Insert for the dental options offered by your Plan.

DMO BENEFITS AND SELF-FUNDED BENEFITS COMPARED

While the specific benefits offered by each DMO differ, they share the following common features in comparison to the Self-Funded Plan:

- Deductibles (the amount you pay before your Plan pays anything), if any, are usually smaller under the DMO options than under the Self-Funded Dental Plan.
- The co-pays under DMO options (the amount you pay out-of-pocket for each procedure) are usually fixed amounts. For some procedures, such as preventive or diagnostic procedures, there may be no co-pay. Under the Self-Funded Plan you usually pay a percentage of the billed charge after the deductible is met. In addition, if the dentist charges you more than the usual reasonable and customary fee, you pay the excess.
- DMO plans limit coverage to a panel of providers. **If you go to a dentist who is not on the panel, there is no coverage and you pay the entire bill.** If you are considering a DMO option, review the panel of dentists carefully. In some areas, your choice of dentists may be limited. Under the Self-Funded Plan you can go to any licensed dentist and still receive dental benefits for treatment.

The specific benefits and panel of dentists for each DMO are available from the DMO. Contact the Administrative Office if you did not get this information when you became eligible or during open enrollment if you are considering switching dental plans. As noted on page 7, **if you are in a Plan**

[*] Plans PPK and PPAV offer no dental benefit.

that only offers DMO coverage (in other words, there is no Self-Funded Dental Plan option) **you will not be covered for dental treatment, even if otherwise eligible, until you enroll in a DMO option.** You can obtain an enrollment form from the Administrative Office. The remainder of this section describes the common features of the Self-Funded Dental Plans. See your Benefit Insert for details applicable to your dental plan.

SELF FUNDED DENTAL PLAN: SUMMARY OF BENEFITS

The following chart is intended to provide a convenient quick-reference guide to benefits under the Self-Funded Dental Plan. More detailed information, including conditions for payment of different benefits, follows the chart.

Summary of Dental Benefits	
General Plan Features	
Calendar-year deductible	See your Benefit Insert.
Maximums for benefit payments	Benefits are limited to an annual maximum amount. See your Benefit Insert.
Benefits for Covered Services	
Benefit	After the deductible is met, the Plan pays a percentage of the billed charge. The percentage paid generally depends on the type of procedure. Diagnostic and preventive procedures are usually reimbursed at a higher percentage than Basic Restorative procedures (e.g. fillings, root canals, oral surgery) and Major Restorative or Prosthodontic procedures (crowns, dentures, bridges). See your Benefit Insert for the percentage payable by the Plan for each type of procedure.
Usual, Reasonable and Customary	If the dentist bills more than the usual, reasonable and customary fee for a procedure, you pay the difference.
Orthodontics	Some Plans cover orthodontics, others do not. Those plans that do cover orthodontics cap the benefit at an annual maximum. Consult your Benefit Insert for details.
Other Features	
Predetermination	Although the Self-Funded Dental Plan does not require predetermination before treatment is done, it is RECOMMENDED that you have your dentist submit any treatment plan expected to cost more than $500. That way, you will know what your out-of-pocket cost will be and whether the work your dentist proposes will be covered—see below.
Frequency of treatment	Some procedures are only covered at specified intervals. For example, cleanings are limited to twice in a calendar year, and crowns and bridges will not be replaced for five years. See your Benefit Insert for details.
Exclusions from coverage	Certain services such as grafts, implants and cosmetic work are NOT covered. See list beginning on page 52 for details.

HOW THE SELF FUNDED DENTAL PLAN WORKS

Under the self-funded dental program, you may use any licensed dentist. Benefits are based on:

Deductible The amount you pay each calendar year towards covered dental treatment before the plan pays anything. The deductible does not apply to preventive services.

Percentage Paid After the deductible is met, most dental plans pay a percentage of the covered **c**harge based on the type of service received. Generally, a higher percentage of the charge is paid for diagnostic, preventive and basic restorative procedures than for major restorative and prosthodontic services.

Example First visit during the calendar year is for cleaning and x-rays. The charge is $225. Your plan has a $75 deductible and pays 90% for preventive work. Your benefit is $135, or 90% of $150 (total charge of $225 less the $75 deductible).

UCR The covered charge is limited to the usual, customary, and reasonable charge for the work done. If the dentist charges more than a UCR fee, the benefit paid will be the applicable percentage of the UCR fee. For example, if your dentist charges $250 when the UCR fee is $200, the benefit will be based on the customary fee. If it was restorative work payable at 80% then your benefit will be $160 (80% of $200) **not** $200 (80% of $250) and your out-of-pocket cost will be $90 ($250 less the $160 benefit) not the $50 (20% of $250) you might have expected. This is one reason the Plan recommends getting a predetermination of benefits, so you will know if there is going to be an out-of-pocket cost. You should also make sure that your dentist is part of the Anthem Dental preferred provider group (PPO). You can confirm that your dentist on that list by going to www.wellpoint.com.

Maximums Most dental plans have an annual maximum benefit. Once you have received the maximum benefit for the year, no more benefits will be paid for work done during that year (including preventive care), even if the treatment would otherwise be covered.

Benefit Insert Your Benefit Insert gives specific information covering your deductible, what percentage is paid for the different types of services and the annual benefit maximum.

Orthodontia Unless it is listed as a covered service in your Benefit Insert, there are no benefits for orthodontic work. If orthodontic work is covered, benefits are subject to a lifetime maximum.

Do not forget that if you are covered by a prepaid dental option instead of the self-funded dental program, you **must** use a dentist in the prepaid program's network.

RECOMMENDED PREDETERMINATION

After an examination, your dentist will determine the treatment to be provided. If the cost of the services will be $500 or more, it is strongly recommended that your dentist get a predetermination of benefits from the Administrative Office before proceeding with the proposed treatment. Predetermination is always recommended for orthodontic work

To obtain a predetermination of benefits, your dentist should submit an attending dentist's statement to Plan dental PPO Anthem Dental (www.wellpoint.com) or the Administrative Office at the following address:

Bay Area Automotive Group Welfare Fund
4160 Dublin Blvd, Suite 100
Dublin, California 94568

Fax #: (925) 833-7301

(*For this purpose, your dentist should use an American Dental Association (ADA) Dental Claim Form.*) The Administrative Office can then advise you and your dentist ahead of time whether the proposed treatment is covered under the Plan and, if so, the amount that will be payable by the Plan for that treatment.

COVERED SERVICES

Subject to the dental benefit maximums shown on your Benefit Insert, the Fund pays the percentages shown on the Benefit Insert for the covered charges or services received from a licensed dentist. To be covered, services must be necessary and customary, as determined by the standards of generally accepted dental practice. Treatment begun before you are eligible for dental benefits is not covered, even if some of the work is done after you are eligible.

The following is a list of the types of services covered by the Plan.

DIAGNOSTIC AND PREVENTIVE SERVICES

The Plan pays the percentage of covered charges shown on your Benefit Insert for the following types of service:

- Diagnostic services:
  - oral examinations,
  - X-rays (full-mouth x-rays limited to once every 3 years; bitewings once in 12 months),
  - diagnostic models,
  - emergency palliative treatment,
  - specialist consultation.
- Preventive care:
  - prophylaxis (cleaning) (limited to two times in a calendar year),
  - fluoride treatment for children to age 18 (limited to two times in a calendar year),
  - periodontal maintenance (limited to once every 3 to 4 months, three times a year) following the completion of active (surgical or non-surgical) periodontal therapy.

BASIC SERVICES

The Plan pays the percentage of covered charges shown on your Benefit Insert for the following:

- Fillings—amalgam, synthetic porcelain, and plastic restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).

  Note: The Plan only allows amalgam on posterior teeth. If synthetic porcelain or plastic restoration is done, the Plan will pay the benefit for an amalgam restoration.

- Space maintainers.
- Sealants on permanent first and second molars for children to age 15.
- Oral surgery—extractions and certain other surgical procedures, including pre- and post-operative care.
- Endodontics—treatment of the tooth pulp.
- Periodontics—treatment of gums and bones supporting teeth.

MAJOR RESTORATIVE SERVICES

The Plan pays the percentage of covered charges shown in your Benefit Insert for the following:

- Crowns and cast restorations for treatment of carious lesions that cannot be restored with amalgam, synthetic porcelain, or plastic restorations.

PROSTHODONTIC SERVICES

The Plan pays the percentage of covered charges shown in your Benefit Insert for the following:

- Prosthodontics (procedures for construction or repair of fixed bridges or partial or complete dentures).

ORTHODONTIC SERVICES

If your Plan has coverage for orthodontia (some do not cover orthodontia—see your Benefit Insert), the Plan pays a percentage of covered charges, usually up to a cap, after satisfaction of an annual deductible. Refer to your Benefit Insert for the level of benefit available (if any).

EXCLUSIONS FROM DENTAL COVERAGE

Dental benefits will not be paid for the following:

1. Dental x-ray examinations made because of dental injury resulting from an accident (covered under the medical plan).
2. Any procedure performed primarily to improve the appearance of the patient, unless performed after an accident to repair damage from the accident.
3. Any crown replacement made less than 5 years after preceding placement unless replacement is for the purpose of extending a fixed bridge.
4. Replacement of fixed bridge, a removable partial or full denture, or an orthodontic retainer for a period of 5 years after the initial placement of the prosthetic (unless, for purposes of a bridge) it is necessary to extend the fixed bridge. This exclusion applies even if the prosthetic is lost or stolen.
5. Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services.

6. Extra-oral grafts or implants or the removal of implants, except under special circumstances when pre-authorized by the Administrative Office.
7. Treatment related to TMJ (Temporomandibular Joint) is not a covered benefit under the dental plan.
8. Prosthodontic services or any procedure started before the patient became eligible for services under the Plan.
9. Prescribed drugs, premedication, or analgesia, unless medical necessity is documented.
10. Experimental procedures.
11. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including, but not limited to, cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth). Repair of cleft palate is covered under your Medical Plan.
12. Any treatment performed by someone other than a licensed Dentist, except for charges for dental prophylaxis (cleaning and scaling) performed by a licensed dental hygienist.
13. Any hospital costs or dentistry fees for hospital treatment.
14. Any service or supply excluded under the Plan's "General Exclusions and Limitations."

HOW TO FILE A CLAIM FOR DENTAL BENEFITS

Your dentist's office should also have standard claim forms that can be used.

Complete your part of the claim form and have your dentist's office complete the rest of the claim form. The completed claim should be sent to Anthem Dental electronically via Anthem's e-claims website (www.wellpoint.com) or mailed to:

Anthem Dental Claims
PO Box 659444
San Antonio, Texas 78265-9444

DEADLINE FOR SUBMISSION

You should submit your claim as soon as possible after services are received. Claims received more than 12 months after the date of service will be denied as untimely.

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see "Filing a Claim for Benefits and Claim Appeal Procedures" later in this Benefits Booklet.

DISENROLLMENT FROM DENTAL AND VISION BENEFITS

You and your dependents can disenroll from the Plan's vision and dental coverage. You may only disenroll from dental coverage if you have not changed your dental coverage within the past twelve (12) months (in other words, you have not elected into one of the Plan's pre-paid dental options or moved from a pre-paid dental option into the self-funded dental option). Please note that except in very rare circumstances, disenrolling from vision or dental coverage will not be in your best interest. Your employer's monthly contribution for the Plan coverage (and your share of the contribution) will not be reduced if you disenroll. After you disenroll, you will not be able to re-enroll in vision or dental coverage for twelve (12) months. Please call the Plan Administrator at 1-800 267-3232 if you have any questions regarding whether disenrolling from vision or dental coverage makes sense for you.

VISION BENEFITS

In this section you will find:

- A quick-reference guide to vision benefits
- Details on how the plan works
- Covered services and supplies
- Optional extras
- Additional discounts
- Low vision benefit
- Exclusions from coverage
- Information on filing claims

Check your Benefit Insert to determine whether your Plan offers vision benefits.

If your Plan's benefits package includes vision benefits, these benefits are provided through Vision Service Plan (VSP).

Your vision benefits cover you and your enrolled dependents for regular examinations and for lenses and frames necessary to correct your vision.

HOW THE VISION PLAN WORKS

VSP PROVIDERS

As noted above, vision care services are provided through Vision Service Plan (VSP). You can receive a higher level of benefits by obtaining services and supplies from a VSP provider. VSP has established a large state-wide panel of opticians, optometrists and ophthalmologists. You can obtain a list by calling VSP at 1 (800) 877-7195 or by logging on to the VSP website at www.vsp.com and using the "Find a Doctor" feature.

Steps for using a VSP provider are as follows:

- Call any VSP participating provider to make an appointment (you do not need to obtain a benefit form from VSP first). Identify yourself as a VSP member and provide the last four digits of your VSP member identification number (the last four digits of your Social Security number) and the name of the group plan ("Bay Area Automotive Group Welfare Fund").
- After you have scheduled an appointment, the VSP participating provider will contact VSP to verify your eligibility and plan coverage.
- When you go for your visit, pay the provider any amount due if you have incurred charges that are not covered in full. VSP will pay the provider directly for the balance of the charges.

NON-VSP PROVIDERS

You may choose to use a non-VSP provider instead (any licensed optometrist, ophthalmologist, or dispensing optician). However, Plan benefits will then be limited to the applicable reimbursement allowances.

If you use a non-VSP provider, you will need to pay the provider in full at the time of your visit, then file a claim with VSP for reimbursement of the applicable amount. See "How To File A Claim For Vision Benefits" on page 59.

COVERED SERVICES AND SUPPLIES

The Plan provides benefits for the services described below. You are responsible for the cost of any upgrades or services or supplies not covered by the Plan or, if you get elective contact lenses or use non-VSP providers, any costs beyond the reimbursement allowances.

Benefits for frames and lenses include such professional services as prescribing and ordering proper lenses, assisting in the selection of frames, verifying the accuracy of the finished lenses, and proper fitting and adjustment of glasses.

Note: You may use **either** a VSP provider **or** a non-VSP provider. You may not use your full benefit under a VSP provider and then get a second benefit by going to a non-VSP provider.

Refer to your Benefit Insert for the amount of your co-payment and VSP allowance for the services discussed below. The level and frequency of benefits is set forth in the following chart.

Summary of Vision Coverage			
Nature of Service	**Frequency of Coverage**	**Benefit**	
		VSP Provider	**Non-VSP Provider**
Vision exam	Once every 12 months	Covered in full subject to copay*	Covered up to an amount equal to the VSP examination allowance less the copayment*
Corrective lenses (single vision, lined bi-focal, lined tri-focal and lenticular)	Once every 12 months if visually necessary	Covered in full*	Limited to VSP corrective lens allowance*
Frames	Once every 24 months, if necessary	Up to retail frame allowance for VSP providers*	Up to retail frame allowance for non-VSP providers*
Contact lenses	Once every 12 months in lieu of all other benefits for lenses and frames	Benefit depends on whether the contact lenses are visually necessary or elective. The benefit is limited to an allowance that is higher if you use a VSP provider. See below.	

*Copay of $10 applies to exam and/or lenses/frames

Visually necessary means services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative, as determined by VSP.

CONTACT LENSES

The benefit for contact lenses depends on whether the contact lenses are visually necessary or elective. In both cases, the benefit replaces the benefit for lenses and frames. When you obtain contact lenses you are ineligible for eyeglass lenses for 12 months and eyeglass frames for 24 months.

VISUALLY NECESSARY CONTACT LENSES

Coverage of lenses at the visually necessary level (see your Benefit Insert) must meet VSP criteria for necessity. Prior authorization is not required. The plan covers 75% of the doctor's "usual reasonable and customary" fee, up to the maximum set by VSP. You are responsible for the balance.

If you use a non-VSP provider to obtain visually necessary contact lenses, the plan will provide a limited allowance.

ELECTIVE

Contact lenses that are not determined to be visually necessary will be considered elective. The Plan will cover up to the VSP allowance for elective contact lenses towards the cost of contact lenses and the associated fitting and evaluation examination. The fitting and evaluation exam is in addition to your routine vision examination and is done to ensure the proper fit of contacts. This allowance replaces the benefit for lenses and frames. The VSP allowance for elective contact lenses is higher if you use a VSP provider. Consult your Benefit Insert.

OPTIONAL EXTRAS

Your vision benefits are designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the plan will pay the basic cost of the allowed lenses and frames and you will pay the additional costs for the options:

- a frame that costs more than the plan allowance,
- oversize lenses (56 mm and over),
- photochromic lenses,
- tinted lenses except Pink #1 and Pink #2,
- progressive J & K (CR-39 plastic and glass only) lenses,
- progressive flat top lenses,
- scratch coating,
- anti-reflective coating,
- cosmetic lenses or optional cosmetic processes,
- UV (ultraviolet) protected lenses,
- low vision cares other than that specified under "Low Vision Benefit" later in this section.

ADDITIONAL DISCOUNTS

If you would like an additional pair of glasses or would like to be fitted for contact lenses in addition to glasses, you can take advantage of the plan's additional discounts program. Discounts are available only if you use VSP providers.

ADDITIONAL PAIRS OF EYEGLASSES

You will be entitled to a discount of 20% toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a VSP provider. "Additional pair" means any complete pair of prescription glasses purchased beyond the benefit frequency allowed under the plan.

PROFESSIONAL SERVICES FOR CONTACT LENSES

You will also be entitled to a discount of 15% on professional fees for elective contact lens evaluations and fittings. To receive this discount, you must receive these services from the VSP doctor who performed your covered eye examination and you must receive them within 12 months of when you had the exam. Discounts are applied to the doctor's usual reasonable and customary fees for such services.

Contact lens **materials** will be provided at the doctor's usual reasonable and customary charges, with no discount.

The discount available is subject to change.

Obtaining Prior Authorization for the Low Vision Benefit

Prior authorization is required for the low vision benefit discussed below.

Your eye care provider will need to furnish VSP with the information it needs to decide whether prior authorization should be granted. VSP providers will have a pre-certification form they can use for this purpose. Non-VSP providers should contact VSP to find out what is needed.

Once a request for prior authorization is received (assuming it has all the required information), a decision is generally made within 3 to 5 days.

If VSP decides you are not eligible for the low vision benefit, you may appeal that decision as explained in "Payment of Claims and Appeal Process" beginning on page 84 of this Benefits Booklet.

LOW VISION BENEFIT

If you have severe visual problems that are not correctable with regular lenses, you may be eligible for supplementary testing and supplemental care aids under the plan's "low vision benefit." **Payment of the low vision benefit is subject to prior authorization by VSP** (*see box above*).

Supplementary Testing means complete low vision analysis and diagnosis with a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated. Supplemental Aids include subsequent low vision aids as visually necessary or appropriate.

If you use a VSP provider, Supplementary Testing is covered in full and Supplementary Aids are covered at 50% of cost as determined by VSP subject to the VSP two-year benefit maximum shown on your Benefit Insert. If you use a non-VSP provider, your allowance for Supplementary Testing as shown on your Benefit Insert is capped and you will be responsible for any Supplementary Testing charges over this amount. Your reimbursement for Supplemental Aids will be limited to 50% of what VSP would pay a VSP provider. You will be responsible for your copayment (the other 50% of what would be due a VSP provider), plus any amount beyond what VSP would have

paid to a VSP provider for Supplemental Aids you receive. Benefits are subject to a two-year maximum low vision allowance as shown in your Benefit Insert.

EXCLUSIONS FROM VISION COVERAGE

No benefits will be paid for professional services or materials connected with the following:

- orthoptics or vision training and any associated Supplemental Testing except as part of low vision care as preauthorized by VSP,
- plano lenses (less than a ±.50 diopter power),
- two pairs of glasses in lieu of bifocals,
- replacement of lenses and frames furnished under this plan that are lost or broken, except at the normal intervals when services are otherwise available,
- medical or surgical treatment of the eyes, including radial keratotomy or any form of surgical vision correction,
- corrective vision treatment of an experimental nature,
- costs for services and/or materials above Plan benefit allowances,
- the additional costs associated with the items listed under "Optional Extras,"
- services and/or materials not indicated in this section as covered benefits,
- any service or supply excluded under the Plan's "General Exclusions and Limitations."

HOW TO FILE A CLAIM FOR VISION BENEFITS

Note: *The discussion below applies to "post-service claims"—claims you submit after you have received a service. Requests for required pre-authorization are also considered claims. See the box "Obtaining Prior Authorization for Coverage of Necessary Contact Lenses or the Low Vision Benefit" earlier in this section and "Payment of Claims and Appeal Process" for more information on those types of claims.*

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

If you use a non-VSP provider, you will need to file a claim for reimbursement of the applicable amount. File your claim online at www.vsp.com. If you are unable to file online, call VSP at 1 (800)-877-7195 to have an Out-of-Network Reimbursement Form mailed or faxed to you and mail the completed form with your itemized receipt to VSP at the following address:

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

DEADLINE FOR SUBMISSION

You should submit your claim as soon as possible after services are received. Claims received more than 180 days after the date of service will be denied as untimely.

QUESTIONS?

If you have any questions about submitting your claim, contact VSP at www.vsp.com and click on "Contact Us" at the bottom of the page or call 1 (800)-877-7195.

For information on what to do if you disagree with the decision made in regard to your claim, see "Filing a Claim for Benefits and Claim Appeal Procedures" later in this Benefits Booklet.

You can "opt out" of vision coverage – see the discussion of opt out on page 54.

LIFE AND AD&D BENEFITS

In this section you will learn about:

- Life insurance
- Accidental Death & Dismemberment insurance
- Exclusions & limitations
- Information on filing claims

Life and accidental death and dismemberment (AD&D) benefits are offered through a policy issued by Prudential Insurance Company of America. Check your Benefit Insert to determine if your Plan has Life and AD&D benefits. If you do have these benefits, your Benefit Insert will also tell you how much coverage you have. In addition, if you do have this coverage, an insurance certificate issued by the insurance company is available upon request which explains the policy terms in detail.

HOW THE PLAN WORKS

The Life and AD&D benefits help protect you and your family against the financial consequences of death or serious injury. If you are not actively at work on the date your coverage would otherwise begin, coverage will be delayed until you return to work. The benefit for active employees is:

- A lump-sum benefit to your beneficiary in the event of your death.
- A lump-sum benefit to you in the event of accidental dismemberment or certain other serious injuries. An AD&D benefit goes to your beneficiary in the event of your accidental death. The AD&D benefit is generally expressed as a percentage of the life insurance benefit.
- Under some Plans, a lump sum benefit to you in the event of the death of your spouse and/or your dependent children. If one of them dies, a lump sum benefit is paid to you. Your Benefit Insert will state whether your Plan provides dependent life insurance coverage.

The dollar amount(s) of your coverage are shown on the Benefit Insert for your group. (Once you reach age 70, the amount of your coverage is reduced by 50%.)

LIFE INSURANCE

If you die while you are eligible for benefits, your designated beneficiary or beneficiaries will receive a lump-sum benefit. The amount of this benefit, which is shown in your Benefit Insert, depends on your Plan and/or Collective Bargaining Agreement.

YOUR BENEFICIARY

When you enroll you will be asked to fill out a death benefit beneficiary designation form. You may name any person or persons you wish, and you may name the portion of the benefit that is to go to each beneficiary. If you do not name the portion that is to go to each of multiple beneficiaries, then the benefit will be equally divided among the beneficiaries you have listed.

If you do not designate a beneficiary or if your beneficiary dies before you, this benefit will be paid in full (in the following order) to the surviving individual(s) in the first of the following groups that has at least one surviving member:

- your spouse or domestic partner,
- your children,
- your parents,
- your siblings,
- your estate.

Changing Your Beneficiary

You may change your beneficiary designation at any time by completing a new beneficiary designation form and uploading it to the website on the Member Portal at www.baag.org or by sending it to the Administrative Office. The change or changes will be effective when the Administrative Office receives the new form. You do not need anyone's consent to change your beneficiary designation. However, designation or revocation of a beneficiary by any means other than a signed beneficiary form provided by and filed with the Administrative Office will not be effective.

DEPENDENT LIFE INSURANCE

Your Plan may also provide a limited life insurance benefit in the event of the death of:

- your spouse or domestic partner.
- your eligible dependent child between the ages of 14 days and 19 years (age 21 in the case of full-time students) who is not on active duty in the armed forces of any country.

If your dependent is confined for medical treatment at home, a hospital or elsewhere, coverage will be delayed until the dependent's final medical release from all such confinement.

If offered by your Plan, the amount of this benefit which is paid to you if your spouse or child dies, is shown on your Benefit Insert.

"Eligible dependent child" means an unmarried child who chiefly depends on you for support, and includes your stepchild, foster child, and a child who is adopted or has been placed with you for adoption.

Coverage for your dependents generally ends on the earliest of:

- the date your coverage ends, or
- the date the person no longer qualifies as an eligible dependent.
- the date the group policy terminates.
- the date your employer stops participating as a contributing employer in the Plan.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

The AD&D benefit is paid if you die or sustain any of the following as a result of an accident.

Loss	Percentage of Employee Life Insurance Amount Paid
Death	100%
Both hands (above wrist)	100%
Both feet (above ankle)	100%
Sight in both eyes	100%
One hand and one foot or one hand and sight in one eye or one foot and one eye	100%
Speech and hearing	100%
Quadriplegia (paralysis of both upper and lower limbs)	100%
Paraplegia (paralysis of both lower limbs)	75%
One hand	50%
One foot	50%
Sight in one eye	50%
Speech	50%
Hearing	50%
Hemiplegia (paralysis of both limbs on one side of the body)	50%
Thumb and index finger on same hand	25%

Benefits for accidental loss are payable only if all of the following conditions are met:

- The accidental bodily injury is sustained while you are eligible for benefits;
- The loss results directly from that injury and from no other cause;
- You suffer the loss within 365 days after the accident.

No more than the amount of insurance will be paid for all losses resulting from injuries sustained in a single accident.

YOUR BENEFICIARY

Your beneficiary for the accidental death benefit is the same as your beneficiary for life insurance. The death benefit that is paid under AD&D is in addition to the life insurance benefit described in the previous section.

EXCLUSIONS FROM ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE

AD&D benefits cannot be paid for any of the following:

- self-inflicted injury,

- suicide or attempted suicide, while sane or insane,
- injuries that arise out of any military conflict or act of war, whether declared or not, and injuries sustained while in full-time military service for more than 30 days (this does not include Reserve or National Guard active duty for training),
- a loss resulting from sickness, or medical or surgical treatment of sickness,
- war or act of war, whether declared or not,
- any loss resulting from commission of, or attempt to commit, a felony,
- injury sustained while intoxicated or under the influence of any narcotic unless administered or consumed on advice of a doctor,
- injury sustained while participating in these hazardous sports: scuba diving, bungee jumping, skydiving, parachuting, hang gliding, or ballooning,
- loss resulting from an infection (except (a) a pyogenic infection resulting from an accidental cut or wound; or (b) a bacterial infection resulting from accidental ingestion of a contaminated substance),
- injury resulting from air travel (including getting in, out, on or off the aircraft) when you are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers, performing as a pilot or crew member, or riding as a passenger in an aircraft owned, leased or operated by your Participating Employer.

FILING CLAIMS FOR LIFE AND AD&D BENEFITS

If you die, your family or beneficiary should notify the Administrative Office immediately. To claim a dismemberment benefit, you or your representative should notify the Administrative Office. The Administrative Office will advise what forms and certificates need to be filed in order to receive the life insurance or AD&D benefit. There is more information on claims and appeals procedures in the section called "Filing a Claim for Benefits and Claim Appeal Procedures."

WHEN LIFE AND AD&D COVERAGE ENDS

Your coverage ends on the earliest of the following:

- the date your eligibility for Plan benefits ends,
- when premium payments or contributions to the Plan on your behalf end,
- the date the group policy terminates,
- when your Employer stops participating as a contributing Employer in the Plan.

Coverage for your dependents generally ends on the earlier of the date your coverage ends or the date the person no longer qualifies as an eligible dependent.

DISABILITY EXTENSION

If you become totally disabled while eligible for this benefit and before you reach age 60, life insurance protection is extended for as long as you remain disabled. To receive this protection, you

must provide notice of disability within 12 months after the disability began. If you die within one year after your Total Disability started and before you give proof of your disability to the insurance company your claim must be filed within one year after your death or no benefits will be paid.

The amount of life insurance coverage you have during this period may be different than the amount you had as an active employee.

Extended life insurance coverage ends if your disability ends, if you fail to provide requested proof of disability, or you convert your life insurance to an individual policy.

For the purpose of determining your life insurance benefit Total Disability means that:

- you are not working at any job for wage or profit; and
- due to sickness, injury or both, you're not able to perform for wage or profit the material and substantial duties of any job for which you are reasonably fitted by your education, training or experience.

CONVERSION PRIVILEGES

When your Plan coverage ends, you, and in certain cases your covered dependents, may be entitled to convert your group life insurance coverage to an individual policy with the insurance company. The amount of this coverage will generally be less than the amount of your group coverage. You generally must elect this coverage by the *later* of:

- 31 days after group coverage ends, or
- 25 days after you get written notice of the conversion privilege, but in no event more than 92 days after your group coverage ends.

You can get more information on conversion rights from the Administrative Office or the insurance company.

EMPLOYEE SHORT-TERM DISABILITY INCOME COVERAGE

In this section you will find:

- A quick-reference guide to your benefits
- How the plan works
- Covered disability
- Exclusions from coverage

The benefits described in this section are available only to employees (not dependents) and only if Short-Term Disability Income benefits are offered by your Plan. The benefits are also sometimes called "time-loss" benefits. ***Short-Term Disability Income benefits are not provided by all Plans and you should check your Benefit Insert to determine if your Plan offers this coverage.***

Summary of Employee Short-Term Disability Income Coverage	
Schedule of Benefits	
Weekly Benefit	Depending on your Plan either: • a fixed weekly amount (at the date of printing, $200 per week or $28.57 per day) after the waiting period, or • a percentage of your contract wage rate (at the date of printing, 35% of the hourly wage for an 8-hour day payable for each work day missed after the waiting period). See your Benefit Insert for current rates.
Disability Waiting Periods Fixed Weekly Amount Percentage Benefit Amount	 Illness related disability 13 days Injury No waiting period Hospitalization (inpatient only) No waiting period Illness related disability 3 days Injury No waiting period Hospitalization (inpatient only) No waiting period See your Benefit Insert for current waiting periods.
Maximum Payment Period Fixed Weekly Amount Percentage Benefit Amount	 Payment period maximum 182 days Payment period maximum 130 days See your Benefit Insert for applicable maximum payment periods.
Types of Disabilities Covered	See your Benefit Insert. For some groups only non-occupational disabilities are covered. For other groups both occupational and non-occupational disabilities are covered.

HOW THE DISABILITY BENEFIT WORKS

A benefit will be paid to you if you become totally disabled while you are eligible for benefits under the Plan's eligibility requirements (see above). Benefit payments start once you satisfy the

waiting period and continue for the maximum period described in your Benefit Insert. **To collect on your disability benefit you must complete the BAAG disability form and submit it to the Plan within 90 days from the date of onset of the disability.** No benefits can be paid after the maximum period, even though you may still be disabled. For partial weeks, the daily benefit is:

- where the benefit is a fixed amount: one-seventh of the weekly benefit shown in the above chart,
- where the benefit is a percentage of wages: one-fifth of the weekly benefit payable for each workday (Monday through Friday) missed. The benefit is based on an 8-hour day at the employee's existing straight-time wage rate.

To receive benefits you must be "totally disabled" and you must be under the care of a physician.

The Disability Waiting Periods and the Maximum Payment Period apply separately to each covered disability and are shown in the above chart.

COVERED DISABILITY

Totally Disabled. For purposes of eligibility for this benefit, Totally Disabled means the complete inability due to disease or bodily injury to perform the regular tasks required for employment under the Collective Bargaining Agreement. In no event will an individual be considered disabled if engaged in any gainful occupation.

Certified by a Doctor. You are only considered to be disabled during the period of time your doctor so certifies. This means that if you are off work but your doctor has not certified these days as days you were disabled, then these days will not count towards your waiting period.

Period of Disability. Any two periods of total disability will be considered one period of disability unless:

- you returned to work on a full-time basis for at least two consecutive weeks between the two periods of disability; or
- the later disability is due to an injury or illness entirely unrelated to the causes of the earlier disability and begins after you have returned to work on a full-time basis.

EXCLUSIONS FROM SHORT-TERM DISABILITY INCOME COVERAGE

No disability benefit will be paid for:

- a disability for which benefits are excluded by the Plan, or
- any period during which you are not under the care of a physician who has certified that you are totally disabled.

FILING CLAIMS FOR SHORT-TERM DISABILITY INCOME BENEFITS

To claim benefits, have your employer complete its portion of the Statement of Claim for Time Loss Benefits. Sign the Statement and have your doctor fill out the "Attending Physician's" portion of the Statement. Mail the Statement to the Administrative Office at:

Bay Area Automotive Group Welfare Fund
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
www.baag.org

Contact the Administrative Office if you need forms or any other form of assistance. The Administrative Office will advise you if any additional forms or certificates are needed. There is more information on claims and appeals procedures in the section called "Filing a Claim for Benefits and Claim Appeal Procedures."

DEFINITIONS

In this section you will find definitions for important Plan terms.

Contact the Administrative Office if you have any questions about a definition or if you need information on a term that is not defined here.

This section tells you how important Plan terms are defined.

ACCIDENT/ACCIDENTAL INJURY

An accidental injury is a physical injury resulting from a sudden, violent, and external force which was not expected, could not reasonably have been foreseen, and could not have been reasonably avoided.

ADMINISTRATIVE OFFICE/ PLAN ADMINISTRATOR

The Administrative Office means the office of the contract administrator appointed by the Fund's Board of Trustees. The Administrative Office can be reached at:

Bay Area Automotive Group Welfare Fund
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
1 (800) 267-3232
www.baag.org

ALLIED HEALTH PROFESSIONAL

Allied health professional means a person shown in the following list of allied health professionals, but only if the person is licensed and practices within the scope of the license:

- a dentist,
- a psychologist,
- a marriage, family and child counselor,
- a physical therapist (only if patient is referred by a physician),
- a speech therapist (only if patient is referred by a physician),
- a chiropractor,
- a podiatrist,
- an optometrist,
- an optician,
- a certified acupuncturist.

BARGAINING UNIT

The employees covered by a common Collective Bargaining Agreement providing for participation in the Plan.

BENEFITS BOOKLET

This Benefits Booklet is the common benefit guide to all Plans. This Benefits Booklet, together with the Benefit Insert and your Bargaining Unit, in combination, make up your *Summary Plan Description* and Plan Document.

CALENDAR YEAR

The period beginning January 1 and ending on December 31 of each year. Also see "Plan Year."

CHIROPRACTIC TREATMENT

Any treatment provided, supervised, or directed by a licensed chiropractor (including neuromuscular physical medicine) and incurred while under the care of a chiropractor, even if prescribed by a Doctor and/or performed by a physical therapist.

COLLECTIVE BARGAINING AGREEMENT

A Collective Bargaining Agreement is the written agreement between a Participating Employer and a local Union (or Unions) affiliated with the International Brotherhood of Teamsters (IBT) or International Association of Machinists (IAM) or other labor organization recognized by the Fund's Board of Trustees which provides for employer contributions to the Plan on behalf of a Bargaining Unit of certain employees and has been approved by the Fund's Board of Trustees.

CONTRACT RATE

Contract Rate means a specially negotiated fee for health care services and supplies provided by facilities and providers with whom the Fund and/or its preferred provider organization has a preferred provider contract.

CONVERSION PRIVILEGE

A provision applicable to group life insurance or HMO medical coverage which allows you to change your "group" coverage to individual coverage. You must pay for individual coverage and benefits may be different than group benefits.

COSMETIC SURGERY

Surgery or other treatment performed primarily to alter and reshape normal body structures primarily for the purpose of improving a covered person's appearance.

COVERED CHARGES/EXPENSES

Covered charges/expenses mean expenses covered by the Plan that are:

- Medically Necessary and not Experimental,
- prescribed by a licensed Doctor or Dentist,
- within Usual, Customary and Reasonable (UCR) charge limits,
- certified by the Plan's utilization review organization (at the time of this printing, Anthem Blue Cross of California) when the Plan requires review and certification,
- not excluded from coverage under your Plan,
- within Contract Rates negotiated with preferred providers,
- incurred while the patient is covered by the Plan.

COVERED EMPLOYMENT

Covered employment means employment with an Employer who subscribes to the Trust Agreement and is accepted for participation by the Bay Area Automotive Group Welfare Fund's Board of Trustees.

CUSTODIAL CARE

Treatment, services or confinement, intended primarily to help a person with daily living activities and that are not rendered mainly for their therapeutic value in the treatment of an injury or disease. Custodial care includes personal care such as help in walking, getting in and out of bed, bathing, eating (including tube or gastrostomy), exercising, dressing, using the toilet or administration of an enema, homemaking, such as preparing meals or special diets, moving the patient, acting as a companion or sitter, and supervising medication which can usually be self-administered.

DEDUCTIBLE

An amount of covered charges which you must pay before benefits will be paid (no benefits are payable for covered charges applied toward your deductible). For the deductible applicable to your Plan see your Benefit Insert.

DENTIST

A Doctor of Dental Science or Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Medicine (D.M.D.) licensed to practice Dentistry in the state, country or other jurisdiction in which he or she renders treatment.

DISABILITY

Totally Disabled means the complete inability due to disease or bodily injury to perform the regular tasks required for employment under the Collective Bargaining Agreement. If you are a covered dependent Totally Disabled means the complete inability due solely to disease or bodily injury to engage in the normal activities of a person in good health and of the same sex and age. In no event, will an individual be considered disabled if engaged in any gainful occupation.

For purposes of extended disability coverage under COBRA and Medicare benefits due to disability, Disabled and Totally Disabled refer to the Social Security Administration's determination of Disability.

For purposes of life insurance coverage, see definition of Total Disability beginning on page 64.

DOCTOR

"Doctor" or "Physician" means a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.) or a Dentist (D.D.S./D.M.D.) licensed to practice medicine or dentistry in all its branches, prescribe and dispense all drugs and perform all surgery under applicable laws of the place where treatment is rendered. To the extent that benefits are provided while the individual is practicing within the scope of his/her license, physician includes a podiatrist, chiropractor, psychologist, optometrist and dispensing optician.

DRUG OR MEDICINE

A supply of a drug or medicine that can be lawfully obtained only upon a written prescription by a Dentist or Physician (other than a podiatrist, psychologist or chiropractor) licensed by law to administer such drug or medicine.

DRUG FORMULARY

Specific generic and brand name drugs or medicines appearing on a listing established and reviewed periodically by the Fund's prescription benefit manager (PBM) and/or its affiliates. Drug formularies may vary by Plan. At the time of the publication of this Benefit Guide, OptumRx is the Fund's PBM.

DURABLE MEDICAL EQUIPMENT

Equipment that is designated for repeated use, is mainly and customarily used for medical purposes, and is not generally of use to a person in the absence of a disease or injury. Durable medical equipment includes, but is not limited to, equipment such as hospital beds, wheelchairs, iron lungs, traction apparatus, intermittent positive pressure breathing machines, braces, and crutches.

EMERGENCY

A sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in: (a) death; (b) placing the covered person's health in serious jeopardy; (c) serious impairment to body functions; or (d) serious dysfunction of any body organ or part of the body.

EMPLOYER/PARTICIPATING EMPLOYER

Any Employer party to a Collective Bargaining Agreement accepted for participation in the Fund and providing for health and welfare payments to the Bay Area Automotive Group Welfare Fund, or who has executed a subscriber agreement to be bound by the terms of the Trust Agreement establishing the Bay Area Automotive Group Welfare Fund accepted for participation in the Fund.

EMPLOYER'S EFFECTIVE DATE

The date specified in a subscriber agreement as the first day employees of a Participating Employer may receive benefits under the Plan.

EXPERIMENTAL TREATMENT

Any accommodations, services, supplies, or other items that are determined by the Plan to be a medical or health care procedure or treatment:

- that is not recognized as conforming to safe and accepted medical or health practices,
- in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness established, or
- for which the required approval of a governmental agency has not been granted at the time the services are rendered.

The Fund will determine whether a treatment charged is Experimental. To determine whether a particular accommodation, service, supply or other item is Experimental the Fund may review established utilization review procedures, refer to the current applicable literature and federal and state laws and regulations, and consider any other information it deems relevant or appropriate. Such determination will be conclusive and binding with respect to all concerned parties. In compliance with the Affordable Care Act, the Plan covers participation in clinical trials subject to preauthorization. If participation is preauthorized, the Plan's standard benefits will apply to routine costs, services, and supplies.

FUND (OR WELFARE FUND)

The Bay Area Automotive Group Welfare Fund.

GROUP HEALTH PLAN

Group Health Plan means any plan providing benefits or services which are provided by a group prepayment program supported wholly or in part by employer payments.

HOME HEALTH AGENCY

Home Health Agency means a public or private agency or organization, certified to participate in the Medicare program, that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy, in a home-type environment. An agency must (1) be licensed or certified by the appropriate regulatory authority, if such licensing or certification is required; (2) have policies established by a professional group associated with the agency or organization, which includes at least one registered nurse (R.N.) to govern the services provided; (3) provide for full-time supervision of such services by a physician or R.N.; (4) maintain a complete medical record on each patient; and (5) have a full-time administrator.

HOME HEALTH CARE SERVICES

Home Health Care Services means the following services provided in the home:

- Home Infusion Therapy,

- therapy services provided by a physical therapist, speech therapist, occupational therapist, home health aide services, and nursing care provided by a registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.),
- services that are Medically Necessary for treatment of an illness, injury or condition and ordered by the attending physician and approved by the Plan's utilization review organization.

Home Health Care Services does not mean:

- custodial care or homemaker services, or
- services that are provided by a nurse, home health aide or therapist who resides in the home or who is a member of the participant's family.

HOME INFUSION THERAPY

Home Infusion Therapy means medicine taken at home through a pump or IV that can be maintained by the patient after specific instruction by a registered nurse.

HOSPICE

An alternative type of treatment for terminally ill patients. A hospice facility or program focuses on trying to make death less painful, less stressful, and less fearful for the patient and his or her family. Hospices provide both home and inpatient care, including, but not limited to:

- physician services;
- home health care services;
- physical therapy;
- rental of hospital beds, wheelchairs, and other equipment;
- homemaker services;
- pain control; and
- bereavement and emotional support services for the patient's family.

HOSPITAL

An institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), licensed in the state where it is located and operated according to law, that meets the following requirements:

- it maintains on its premises all facilities necessary for medical and surgical treatment, provides such treatment on an inpatient basis for compensation under the supervision of physicians, and provides 24-hour service by registered graduate nurses, or
- it qualifies as a hospital a mental health facility or psychiatric hospital and is a provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- it specializes in treatment of mental illness, substance abuse, or other related illnesses, provides residential treatment programs, and is licensed in accordance with the laws of the appropriate legally authorized agency, and

- it is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care (either on the premises or by formal arrangement with an acceptable institution) of injured and sick persons, and
- it is not a place for rest or for the aged and is not a nursing or convalescent home.

To the extent treatment is not required for the alcoholism, substance abuse, or for a mental, nervous or emotional disorder, a hospital need not meet the requirement that it specializes in such treatment.

INSERT (BENEFIT INSERT)

The Benefit Insert describes the specific benefits applicable to the Plan in which you are enrolled. In combination with this Benefits Booklet, the Benefit Insert and your Collective Bargaining Agreement comprise your *Summary Plan Description*.

INSURED

You and, if applicable, your dependents when covered under the insured benefits offered by your Plan such as life and AD&D insurance benefits. Refer to your Benefit Insert to confirm whether you and dependents are covered for purposes of insured benefits.

MEDICALLY NECESSARY/MEDICAL NECESSITY

With respect to each service or supply, the term "medically necessary" means that the service or supply meets all of the tests listed below:

- It is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects, and birth defects.
- It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards.
- It is not mainly for the convenience of the covered person or the covered person's physician or other provider.
- It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in an acute care hospital or other facility, this test means that the covered person needs to be confined as an inpatient due to the nature of the services rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through outpatient treatment.

To be covered, Medically Necessary services must be provided by a licensed doctor or recognized practitioner operating within the scope of his or her license. The fact that a physician or other practitioner may prescribe, order, recommend, or approve a service or supply does not necessarily mean it is Medically Necessary.

MEDICARE

The Health Insurance for the aged program established pursuant to Title XVIII of the Social Security Act, including related laws, amendments and regulations.

MENTAL, NERVOUS, OR EMOTIONAL CONDITION

A condition that affects thinking, perception, mood, or behavior. Such conditions are recognized primarily by psychiatric symptoms that appear as distortions of normal thinking or perception, moodiness, sudden or extreme changes in mood, depression or unusual behavior such as depressed behavior, or highly agitated or manic behavior, or by physical manifestations.

Any condition meeting this definition is a mental or nervous illness or disorder, no matter what the cause of the condition may be, either physical, mental, organic, or environmental causes, or any combination. Any condition meeting this definition is included without regard to whether it produces only emotional symptoms or only physical symptoms such as headaches, sweats, trembling, nausea, or hysterical paralysis, or a combination.

Examples of mental, nervous, or emotional disorders or conditions are schizophrenia, manic depression, and other disorders or conditions usually classified in the medical community as psychosis; depressive, phobic, manic, and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive and compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial, and borderline); dementia and delirious states; post-traumatic stress disorder; organic brain syndrome; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; and anorexia nervosa and bulimia.

OPEN ENROLLMENT PERIOD

If you participate in a plan where you may make changes to your medical and dental options, you may change options once every 12 months after your initial election. Each time you change an option (or add or remove dependents in a tiered plan), a new 12-month period begins. Contact the Administrative Office to request the forms to make changes to your medical and/or dental options.

PERIOD OF DISABILITY (WHERE APPLICABLE)

For purposes of hospital benefits, a "period of disability" begins when a covered person is first confined in a facility as an inpatient. For purposes of surgical coverage benefits, a "period of disability" begins when the surgery is first performed. For both types of benefit the "period of disability" ends:

- for you, when you have returned to work or become available for work, and
- for your dependent, when he/she has not been confined in a facility as an inpatient for a period of at least six consecutive months.

For the purposes of Short-Term Disability Income coverage, see definition of "Period of Disability" on page 67.

PHYSICIAN, SEE DOCTOR

PLACEMENT FOR ADOPTION

The date the adoptive parent assumes and retains a legal obligation for total or partial support in anticipation of the adoption.

PLAN

The group welfare benefits applicable to your Bargaining Unit described in this Benefits Booklet and the Benefit Insert and Collective Bargaining Agreement comprise your Summary Plan Description and, together with applicable group insurance policies comprise the Plan Document. No benefits other than those described in such documents are provided under the Plan.

As used in this Benefits Booklet, the word "Plan" also refers to the "Self-Funded Medical Benefit Plan," the "Self-Funded Dental Plan," and the "Prescription Drug Plan."

PROFESSIONALLY RECOGNIZED STANDARDS

Means professionally recognized standards of quality, as determined by the Administrative Office and the Board of Trustees in consultation with inside or outside medical professionals with expertise in the particular area of medicine. To determine such standards, the Fund may elect to use such groups as the American Medical Association, the American Dental Association, their affiliates and successors, peer review groups, professional review groups, and similar groups.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

A psychiatric facility that provides inpatient services for the treatment of mental disorders and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A medical support order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law in that state and which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Plan participant is eligible.

REHABILITATION THERAPY

Therapy by a registered or licensed physical therapist, speech therapist, occupational therapist or cardiac therapist not related to you or your dependents by blood or marriage. Services received from a massage therapist are not covered.

SKILLED NURSING FACILITY

A nursing facility, by whatever name called, that meets all of the following criteria:

- it is an institution, or a distinct part of an institution, that has in effect a transfer agreement with one or more Hospitals,
- it is primarily engaged in providing in-patient skilled nursing care and related services for individuals who require medical or nursing care,
- it is duly licensed by the appropriate governmental authorities,
- nurses are responsible for the care of inpatients,

- it requires that every patient must be under the supervision of a physician,
- it maintains clinical records on all patients,
- it provides 24-hour-a-day nursing services,
- it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals,
- it has in effect a utilization review plan,
- it is eligible to participate under Medicare,
- it is not an institution that is primarily for the care and treatment of mental diseases or tuberculosis.

TOTAL DISABILITY (TOTALLY DISABLED), SEE DISABLED

TRUST AGREEMENT

The Agreement and Declaration of Trust for the Bay Area Automotive Group Welfare Fund, as amended.

TRUSTEES (AND BOARD OF TRUSTEES)

The members of the Board of Trustees, the Plan Sponsor, who are empowered to hold Fund assets, oversee Fund and benefit plan administration and who have sole and exclusive authority to interpret and apply the terms of the Plan and the Trust Agreement.

UNION/PARTICIPATING UNION

A local Union affiliated with the International Brotherhood of Teamsters (IBT), International Association of Machinists (IAM) or other labor organization recognized by the Board of Trustees.

USUAL, CUSTOMARY AND REASONABLE

With respect to any one service or supply, the term "usual, customary and reasonable" means that the service or supply meets the following standards:

- "Usual charge" is a fee regularly charged and accepted as payment in full by the physician to private patients.
- "Customary charge" is a fee level which is in the range of fees customarily charged by physicians of similar training and experience for the same service within the same specific and limited geographical area of the responsible physician's society.
- "Reasonable charge" meets the other two standards and, if reviewed by a committee or organization of the responsible physician's society, such fee is deemed justifiable according to the special circumstances of the particular case in question.

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FILING A CLAIM FOR BENEFITS AND CLAIM APPEAL PROCEDURES

In this section you will find information on:

- Filing a claim for benefits
- Appealing a denied benefit claim

HOW TO FILE A CLAIM FOR BENEFITS

SUBMITTING A CLAIM

To file a claim under this Plan for medical services, your provider should submit the claim directly to Anthem.

To file a claim under this Plan for chiropractic, acupuncture, mental health services, or durable medical equipment, follow these steps:

Obtain a claim form from the Plan Administrative Office or the website.

Complete your portion of the form and have the person providing services complete the rest of the form.

On completion of the form, attach itemized bills or statements and send it to:

Bay Area Automotive Group Welfare Fund
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
1 (800) 267-3232
www.baag.org

Check the section in this Benefits Booklet on the particular type of benefit for information on any additional claim filing requirements.

Send any further bills or statements for any services covered by the Plan to the Administrative Office as soon as you receive them.

Claims for benefits including supporting documentation must be submitted as soon as possible after you first receive medical attention but in no event later than one year after the date services were rendered (except in the event of legal incapacity).

The Fund may, at its own expense, examine the person for whom the claim is made when and as often as it may reasonably require while a claim is pending and, in the case of death, may make an autopsy where not forbidden by law.

For Kaiser coverage, see your HMO materials for information on how to file a claim if necessary. If you participate in a dental HMO (DMO), your DMO materials will have information on filing any claims that may be required.

See below for applicable time limits for processing claims and requirements regarding prior-authorization and utilization review.

TIME ALLOWED FOR PLAN RESPONSE TO FILED CLAIM

To file claims for any of the Plan's health care benefits, follow the procedures as described in this section. The claims procedure you follow will depend on whether your claim for benefits a claim is involving urgent care, a pre-service claim, or a post-service claim.

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

PRE-SERVICE CLAIMS

The Plan Administrator will issue a decision within 15 days after receipt of the claim. If an extension is necessary, then a decision will be issued within 30 days of receipt of the claim. You will receive written notice of the extension before the end of the initial 15-day period, which will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the required information, and you will have 45 days to provide the requested information. The time in which a decision will be issued is delayed from the date the extension was sent until the date you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

URGENT CARE CLAIMS

The Plan Administrator will issue a decision as soon as possible and within 72 hours after receipt of the claim. If more information is required to determine the claim, you will be notified as soon as possible but within 24 hours, and you will be given at least 48 hours to provide the requested information. If you do not provide the requested information within the 48-hour period, your claim will be denied.

POST-SERVICE CLAIM

The Plan Administrator will issue a decision within 30 days after receipt of the claim, unless an extension is necessary, in which case a decision will be issued within 45 days. Written notice of the extension will be provided to you before the end of the initial 30-day period and will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the required information, and you will have 45 days to provide the requested information. The time period in which a decision will be issued is delayed from the date the extension was sent out until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

CONCURRENT CARE CLAIMS

In the case of a concurrent care claim, where health care treatment is reduced or terminated before the end of the approved period of time or number of treatments, the Plan Administrator will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision if you choose to do so and have the appeal decided before the benefit is reduced or terminated.

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

FILING CLAIMS FOR DISABILITY BENEFITS

A claim for disability benefits is a request for disability plan benefits including extended coverage under the Plan for disabled participants ("disability benefits").

For disability benefit claim determinations and claim appeals, the people adjudicating disability claims and disability appeals (such as claim adjudicators and medical or vocational experts) will act independently and impartially.

Get a disability claim form from the Fund Administrator, complete the patient portion of the form, then give the form to your physician to complete the health care provider section and give the employer portion to your employer. Failure to complete any portion of the claim form means your claim will be denied. Return the completed disability claim form to the Fund Administrator (whose contact information is listed at the end of this document).

All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability. Plan benefits will not be paid for any claim submitted after this period.

The Fund Administrator will determine your disability benefits claim no later than 45 calendar days after receipt. You will be notified if you did not follow the disability claim process or if you need to submit additional information or records to prove a disability claim and you have up to 45 calendar days to obtain this additional information. This 45-day period may be extended for up to 30 calendar days provided the Fund Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period that additional time is needed to process the claim, the special circumstances for this extension, and the date by which it expects to render its determination.

If, prior to the end of this first 30-day extension, the Fund Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the expiration of the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. If the Fund Administrator needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information.

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

If the claim for disability benefits is approved, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

If the claim for disability benefits is denied in whole or in part, a notice of this initial denial (an Adverse Benefit Determination) will be provided to you in writing. This notice of initial denial will:

(a) Give the specific reason(s) for the denial of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) Reference the specific Plan provision(s) on which the determination is based;

(c) Contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;

(d) Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

(e) Provide an explanation of the Plan's appeal procedure along with time limits;

(f) Contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;

(g) Describe any applicable contractual limitation periods on benefit disputes (such as the Plan's one year time limit on when a lawsuit may be filed following an appeal denial);

(h) If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request;

(i) If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(j) Include a statement that if a Participant is not proficient in English and has questions about a claim denial, they should contact the Fund Administrator to find out if assistance is available.

APPEAL OF A DENIAL OF A DISABILITY CLAIM

If you disagree with a denial of a disability claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period. You will be provided with:

(a) Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

(b) The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) Automatically and free of charge, provided any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;

(e) Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date;

(f) If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

(g) A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and

(h) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:

1) Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) Provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

The Plan will make an appeal determination according to the following timeframes:

(a) **If an appeal is filed with the Plan <u>more than 30 days</u> before the next Board meeting**, the review will ordinarily occur at the next Board meeting date.

(b) **If an appeal is filed with the Plan <u>within 30 days</u> of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(c) If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than five calendar days after the benefit determination is made.

The Plan may obtain a 45-day extension if you are notified of the need and reason for an extension before expiration of the initial 45-day period.

You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(a) The specific reason(s) for the adverse appeal review decision of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views

presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) Reference the specific Plan provision(s) on which the determination is based;

(c) A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(d) A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) A description of any applicable contractual limitation periods on benefit disputes (such as the Plan's one year time limit on when a lawsuit may be filed following an appeal denial);

(f) If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request;

(g) If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(h) A statement that if you are not proficient in English and have questions about disability benefits, filing a claim for disability benefits or about a claim denial, you should contact the Fund Administrator for assistance.

FILING CLAIMS FOR LIFE INSURANCE AND AD&D INSURANCE BENEFITS

The Fund's life/AD&D insurance carrier will issue a decision within 90 days after receipt of the claim, unless an extension is necessary, in which case a decision will be issued within 180 days. Written notice of the extension will be provided to you before the end of the initial 90-day period and will state the reason(s) for the extension and the date you can expect a decision.

PAYMENT OF CLAIMS AND APPEALS PROCESS

If benefits are payable, claims will be paid immediately unless periodic payments are provided. Periodic payments will be paid as they accrue and at least once per month.

Amounts payable for accidental death will be paid in accordance with the beneficiary provisions. Any other amounts unpaid at the time of your death may, at the option of the Fund, be paid either to your beneficiary or estate, except as provided in the following paragraph.

Exception for a dependent child named in a Qualified Medical Child Support Order. The Plan Administrator may pay benefits:

- to a custodial parent or legal guardian if claim is made for reimbursement of benefits paid for a child named in a Qualified Medical Child Support Order;
- directly to a provider if a custodial parent or legal guardian has made an assignment to the provider for such benefits.

Life insurance payments. If any benefits are payable at the death of the insured, or are payable to a participant or beneficiary who is a minor or is incompetent or incapable of executing a valid release and for

whom no guardian has been appointed, Prudential may pay up to $1,000 of any such benefit to any person or institution determined by Prudential to be equitably entitled thereto. Such payment shall fully discharge any obligation of Prudential or the Fund under the group policy to the extent of such payment.

IF YOUR CLAIM IS DENIED

If any claim under the Plan is denied, you will receive written notice of the decision of the right to appeal the denial. The notice will include a description of (1) the specific reasons for the denial and reference to the specific Plan provisions on which the denial is based; (2) a description of any additional information required and why that information is required to perfect your claim; (3) the Plan's appeal procedures, including applicable time limits and your right to submit written comments, documents, and other information relating to the claim and to request in writing to review or receive copies, free of charge, of Plan documents, records, or other relevant and non-privileged information; and (4) your right to file suit if your claim is denied on appeal.

In addition, if your claim is for medical, dental or disability benefits, you will be notified if an internal rule, guideline, or similar criterion was relied on by the Plan Administrator and, at your request, will be provided with a copy, free of charge, of such rule, guideline, or similar criterion. If your claim is denied based on a medical necessity or other similar exclusion or limit, you will be notified that you may request, free of charge, an explanation of how that exclusion or limit and any clinical judgments apply to your medical circumstances. In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claims will be included.

APPEALING A DENIED CLAIM

If you want to file an appeal of a claim denial, it is important that you do so within the applicable time period specified below. If you do not appeal on time, you may lose your right to file suit in a state or federal court because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court).

- Health and Disability Benefit Appeals

You (or your authorized representative) may appeal a complete or partial denial of the claim by filing with the Plan's Administrative Office a written appeal within *180 days* after your receipt of the claim denial.

- Life Insurance and AD&D Benefit Appeals

  You (or your authorized representative) may appeal a complete or partial denial of the claim by filing a written appeal within *60 days* after your receipt of the claim denial.

You should include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant in support of your appeal. As you prepare your appeal, you may request, free of charge, reasonable access to all documents, records and other information relevant to your claim. You may also request the identity of any medical and/or vocational experts whose advice was obtained in connection with the adverse benefit determination, even if that advice was not relied upon in the claim denial.

The following chart summarizes which entity is responsible for reviewing different types of appeals. For contact information, refer to the section of this Benefits Booklet called "General and Administrative Information."

Where To Direct Your Appeal	
Type of Appeal	**Appeals Administrator**
Eligibility, including:	Board of Trustees
Employer's obligation to make contributions	
Dependent coverage	
Medical Benefits	
Pre-authorization of hospital claims	Anthem Blue Cross
HMO coverage	Kaiser
All other self-funded coverage issues	Board of Trustees

Where To Direct Your Appeal (Continued)	
Type of Appeal	**Appeals Administrator**
Prescription Drug Benefits	
If covered under Self-Funded Plan	OptumRx
If covered under HMO	Kaiser
Dental Benefits	
If covered under Self-Funded Plan	Board of Trustees
If covered under a DMO	Your DMO
Vision Benefits	Vision Service Plan
Drug and Alcohol Rehabilitation Benefits	Teamsters Assistance Program or Anthem Blue Cross
Short-Term Disability Income Benefits	Board of Trustees
Life and Accidental Death & Dismemberment	Prudential/Board of Trustees

HOW AN APPEAL IS DECIDED

As indicated in the chart above, the members of the Plan's Board of Trustees will decide appeals related to eligibility, and coverage for time loss and Self-Funded medical and dental benefits. If you are enrolled in an HMO option, whether medical, dental or otherwise, the HMO is the final decision maker on appeal. When deciding appeals, the Trustees will not defer to the initial adverse benefit determination and will consider all comments, documents, and records and other information you submit, even if they were not submitted or considered during the initial claim decision. Their decision on your appeal will be made based on the record, including any additional documents and comments you submit.

If your claim was denied on the basis of a medical judgment (such as the absence of medical necessity or the use of an experimental or investigational treatment), the Board will consult a health care professional with training and experience applicable to the relevant field of medicine. The professional shall not have been involved in the claim denial nor be the subordinate of any person involved in the denial. Upon request,

you can obtain the name of any professional consulted and the advice (if any) given concerning your claim (even if the Board did not rely on this advice in making its decision).

The time for the Board to issue its decision depends on the type of claim:

PRE-SERVICE AND URGENT CARE HEALTH CLAIMS

You will receive notice of the decision on your appeal within *30 days* for Pre-Service Claims. You may request expedited review of urgent care claim denials by telephone or in writing and submit information in support of your appeal by facsimile and/or telephone, as appropriate. You will receive notice of the decision within *72 hours* of receipt of the appeal.

ALL OTHER CLAIMS

Appeals of Post-Service Claims will generally be decided at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal. If, however, your request for review is received within 30 days of the next regularly scheduled Board meeting, your appeal will be decided at the *second* regularly scheduled Board meeting following receipt of your appeal. In special circumstances, review of your appeal may be delayed until the *third* regularly scheduled Board meeting following receipt of your appeal. You will be notified in writing if an extension is necessary. You will be notified of the decision on your appeal as soon as possible but no later than five days after a decision on your appeal is reached.

DENIAL OF A CLAIM ON APPEAL

If your claim is denied on appeal, you will receive a written notice stating (1) the specific reasons for the decision and specific references to the relevant Plan provisions on which the Trustees' decision is based; (2) your right to receive, on request and free of charge, access to and copies of all documents, records, and other relevant information; and (3) your right to file suit under section 502(a) of ERISA. If your claim is for medical, dental or disability benefits, you will be notified if an internal rule, guideline, or other similar criterion was relied on by the Trustees and will be provided with a copy of such rule, guideline, or other criterion free of charge at your request. If your claim is denied based on a medical necessity or other similar exclusion or limit, you will be provided, free of charge at your request, an explanation of how that exclusion or limit and any clinical judgments apply to your medical circumstances, including information relating to medical or vocational experts whose advice was obtained on behalf of the Trustees in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

EXTERNAL REVIEW

If your appeal is denied under the process described above, you may be able to seek review of your claim by an Independent Review Organization (IRO). Only decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit are eligible for external review. Therefore, appeals concerning whether you or a dependent are eligible for benefits ***are not*** subject to this external review process. Here are the steps for seeking review by an IRO:

- If your appeal involves an ongoing course of treatment, the Plan will continue to provide coverage while your appeal is pending. The Plan will consider your appeal through an expedited review process in this case.
- If the Trustees deny your appeal, you may, within 4 months of the date you were notified of the denied appeal, make a written request for an external review of your claim by an IRO. Within 5 days of your request, the Plan will review your request to determine whether it is eligible for

external review. Your claim may not be eligible for review if you have not exhausted your internal appeal of your claim involves a determination that you did not meet the eligibility requirements (e.g. because an employer did not pay a contribution on your behalf) or sought a benefit that was not covered by the Plan. The Plan will inform you of any issues with your request within one day of completing your review. If your request is eligible for review but incomplete, you will be informed what information is required to complete the request and you will be given the longer of 48 hours, or the remainder of the four-month filing period, to correct the deficiency.

- If you request external review, your claims will be submitted to an accredited IRO together with any documents and information the Plan and Trustees relied upon in considering your claim and internal appeal. You will be informed by the IRO when it has received your claim and provided 10 days to submit any additional information in support of your appeal. If you submit new information, the IRO will share that information with the Plan, which may reconsider your internal appeal.
- The IRO will make independent medical and legal decisions concerning your claim. The IRO will issue its decision within 45 days of receiving your claim for review. If the IRO decides that the Plan must provide additional benefits, the Plan will carry out the decision but may challenge the decision by bringing suit against any necessary parties. If the IRO determines that the internal appeal was correctly decided, and you disagree with that decision, you may bring legal action against the Plan, but if you do so the Plan provides that you must file your action in court within one year of the IRO's decision and you must file it in the U.S. District Court for the Northern District of California (which is located in San Francisco, Oakland, San Jose and Eureka).
- If your appeal involves (a) a medical condition when the timeframe for completion of a standard external review would seriously jeopardize your life or health, or ability to regain maximum function and you previously requested an expedited appeal to the Trustees, or (b) and admission, availability of care, continued stay or health care item for service for which you received emergency services, but have not been discharged from a facility, you may request expedited external review. If it is eligible for expedited review, your claim will be referred as soon as possible to an IRO and you will be informed of the IRO's decision as expeditiously as possible, but in no event more than 72 hours after the IRO receives the claim for review. If the initial notice is not in writing, you will receive written confirmation of the decision within 48 hours of the initial notice.

You are not required to seek external review by an IRO and may instead challenge the Trustees' denial of an appeal by bringing legal action against the Plan, but if you do so you must bring your lawsuit **no later than one year of the date you have received notice that your appeal has been denied.**

DISCRETIONARY AUTHORITY OF BOARD OF TRUSTEES

No employee, dependent, beneficiary or other person shall have any right or claim to benefits under the Plan other than as specified in policies or contracts procured by the Board of Trustees or in the rules and regulations of the Board, or any right or claim to payments from the Fund other than as specified therein. Any dispute as to eligibility, type, amount or duration of benefits or any right or claim to payments from the Fund shall be resolved by the Board under and pursuant to the Plan and the Trust Agreement; and the Board's decision of the dispute, right or claim shall be final and binding upon all parties thereto, subject only to judicial review as provided by federal law. No action may be brought for benefits provided by the Plan or to enforce any right under the Plan until after a claim therefor has been submitted to and determined by the Board of Trustees, and thereafter the only action which may be brought is one to enforce the decision of the Board or clarify the rights of the claimant under such decision.

CLAIM DETERMINATIONS BY HMO OR INSURANCE COMPANY

The decision of the Board of Trustees, with respect to any appeal, shall be final and binding on all persons, except in the following instance. If the benefits involved are provided by an insurance company, HMO or other similar organization or through a pharmacy benefit manager, the Board of Trustees may in its sole discretion permit that organization to conduct the review and make the decision. In such event, the HMO, insurance company or pharmacy benefit manager shall have full discretion to render its decision, and its decision shall be binding on the parties.

ADDITIONAL CLAIMS PROVISIONS

RIGHT TO SUE

A lawsuit to obtain benefits will be deemed untimely if it is filed before:

- you have appealed the denial of your claim,
- the time period for filing an appeal has run, which is one year of the date you are notified of the denial, or
- while your appeal is still pending.

The only court in which such a lawsuit can be filed is the United States District Court for the Northern District of California (which is located in San Francisco, Oakland, San Jose, and Eureka.

The Statement of ERISA Rights, printed on pages 104-105, provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

BENEFIT PAYMENTS

All benefits shall be processed and paid by the Fund to the participant as soon as reasonably practicable after receipt of written proof satisfactory to the Plan covering the occurrence, character and extent of the event for which the claim is made.

BENEFITS NOT SUBJECT TO ALIENATION

Plan benefits shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person; however, a participant may direct that their benefits may be paid to a Hospital, any provider of medical, dental or Hospital services or supplies in consideration for medical, dental or Hospital services rendered or to be rendered, or supplies furnished or to be furnished, or to any other person or agency that may have provided or paid for, or agreed to provide or pay for, any Plan benefits.

RIGHT TO EXAMINE

The Plan, at its own expense, shall have the right and opportunity to examine the person of any participant when and as often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Plan.

PAYMENTS MADE IN ERROR

In the event the Plan erroneously makes benefit payments to a participant in excess of the amounts provided for by this Plan, or erroneously makes benefit payments to a participant for expenses for which benefits are not payable under this Plan, or erroneously makes benefit payments to an individual who fraudulently participates in the Plan based on a misrepresentation of facts, the erroneous amounts so paid shall be repaid to the Trust by the participant or individual. If such amounts are not repaid by the participant or individual, the Plan may deduct the amount erroneously paid from any future benefit payments due the participant or the Trustees may, at their discretion, file suit to recover any amounts due.

COORDINATION OF BENEFITS AND THE PLAN'S RIGHT TO RECOVERY

In this section you will find:

- The Fund's rules on coordination of benefit payments from two or more plans
- The Fund's subrogation/reimbursement policy, under which it may recover duplicate payments

COORDINATION OF BENEFITS

COORDINATION WITH OTHER GROUP HEALTH PLANS

If you or a dependent is covered for benefits under another Group Health Plan (such as your spouse's plan at work) the Plan coordinates the benefits it pays with benefits provided by the other group health plan. Benefits payable by the Plan will not be coordinated with any individual insurance.

The plan that pays first is the "primary plan" and the plan that pays second is the "secondary plan." When this Plan is secondary, it will pay the lesser of the difference between the amount paid by the primary plan and:

- the usual, reasonable and customary allowance for the service, or
- the contracted amount (for contract providers).

Coordination means that benefits are paid so that no more than 100% of your usual, reasonable, and customary expenses will be covered under the combined benefits from all of the following plans: (1) this Plan, (2) any other group, blanket or franchise insurance coverage, (3) group practice and other group prepayment coverage, (4) group service plans, (5) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (6) any coverage provided under governmental programs, and any coverage required or provided by statute.

Order of benefit determination. The following rules are used to determine which plan is "primary." The rules are applied in the following order:

- A plan without a coordination of benefits provision or with a provision that bars coordination with this Plan.
- A plan that covers the individual as an employee, member or non-dependent.
- The plan that covers the individual through present employment instead of a plan which covers the individual through prior employment. "Through prior employment" means as a laid-off or retired employee or as a dependent of a laid-off or retired employee.
- The plan that has covered the individual for the longer period of time.
- For a child covered under both parents' plans, the primary plan is determined by the "birthday rule." The plan covering the parent whose birthday occurs earlier in a calendar year is primary. If both parents have the same birthday, the plan that has covered the parent for the longer period of time is primary.

  Exception to rule regarding dependent children. If the covered individual is the dependent child of parents who are divorced or separated, then the following rules will be used in place of the "birthday rule:"

- The plan of the parent who has been assigned financial responsibility for the child's health care by a court decree (e.g., through a Qualified Medical Child Support Order).
- The plan of the parent who has custody of the child.
- The plan of the stepparent who is married to the parent with custody of the child.
- The plan of the parent who does not have custody of the child.
- The plan of the stepparent married to the parent who does not have custody of the child.

If under any of the above rules this Plan is secondary and the plan that would pay primary under these provisions limits or reduces its payment of benefits because of coordination with this Plan, then this Plan will pay no more than it would have paid as secondary payer had the primary plan paid benefits, notwithstanding coordination with this Plan and without regard to such limitation or reduction of benefits because of coordination with this Plan.

If none of the above rules determines which plan is primary, the allowable expenses shall be shared equally between plans. When applying this rule, the Plan will not pay any more than it would have paid had it been primary.

Because the benefit paid by the secondary plan is reduced by the amount paid by the primary plan, the benefit under the secondary plan cannot be determined until the primary plan pays. Therefore, always submit your claim to the primary plan first. When the primary plan has paid, attach a copy of the Explanation of Benefits when you submit your claim to the secondary plan.

Important note if your spouse is covered by an HMO. If you are enrolled in the Self-Funded Medical Plan, the Plan considers all HMOs to be primary plans. If you are enrolled as a dependent in your spouse's HMO plan, the Plan considers your spouse's HMO to be the primary plan for both you, your spouse and other dependents. Similarly, if your spouse or child is enrolled in both the Plan and your spouse's HMO, your spouse's HMO plan is always primary. This means that if you or your dependent children use a provider affiliated with your spouse's HMO, this Plan's benefits will be limited to covering any copayments that would be owed under your spouse's HMO plan in the absence of coverage under this Plan.

COORDINATION OF BENEFITS WITH MEDICARE

If you are an active employee enrolled in the Plan and are also eligible for Medicare coverage under Parts A and B—whether or not you apply for Medicare benefits—the following rules apply:

The **Plan is primary**—and you file claims with the Plan first—if:

- you are covered under the Plan because of your current employment status, or
- you are eligible for Medicare benefits because you have end-stage renal disease (ESRD) unless:
  - you became eligible for Medicare benefits due to age or disability prior to becoming eligible for Medicare benefits due to ESRD and,
  - The Plan is already permissibly paying secondary because you are not covered on the basis of your current employment status.

In general, the Plan remains primary for the first 30 months if either (1) ESRD is the first reason for Medicare eligibility, or (2) Medicare eligibility is first due to age or Disability and the Plan has already been paying on a primary basis because coverage is provided by virtue of current employment status. At the end of the 30-month period, Medicare will be primary.

Medicare is the primary payer—and you file claims with Medicare first—if you do not have ESRD and you are not in "current employment status."

"Current employment status" means an individual is actively working—or is not actively working and:

- is receiving employer-provided disability benefits that are subject to FICA taxation (i.e., the first six months of disability benefits), or
- retains employment rights in the industry (for example, on a temporary layoff), has not had membership in an employee organization terminated, has group health plan coverage other than COBRA coverage, is not receiving Social Security Disability benefits, and has not received disability benefits from an employer for more than six months.

I**f your dependent is eligible to receive Medicare benefits under Part A or B**—whether or not he or she has actually applied for Medicare benefits—the following rules apply:

The Plan is the primary plan for your dependent if:

- Your dependent is covered under the Plan because of your current employment status, or
- Your dependent is eligible for Medicare benefits due to ESRD, unless:
  - Your dependent becomes eligible for Medicare benefits due to age or disability before becoming eligible for Medicare benefits due to ESRD, and
  - The Plan is already permissibly paying secondary because your dependent is not covered on the basis of your current employment status.

  The Plan is primary payer for the first 30 months your dependent is eligible for Medicare due to ESRD; at the end of the 30-month period, Medicare will be the primary payer.
- Your dependent is disabled and eligible for Medicare—and you are covered under the Plan because of your current employment status.

The Plan is the secondary plan and Medicare is primary if your Dependent does not have ESRD and you are not in current employment status.

The Plan does not reimburse your Medicare Part B premiums. Contact your local Social Security office for more information.

RIGHT TO INFORMATION, PAYMENT AND RECOVERY OF PAYMENT

The Fund may obtain or release any information necessary to carry out these coordination of benefit provisions. You must declare your coverage under any other plan. The Fund can recover from you or your Dependents any amounts overpaid because you failed to inform the Fund of other coverage, including but not limited to offsetting future benefit payments until the amount is recouped.

RIGHT OF REIMBURSEMENT AND THIRD PARTY LIABILITY

The Fund reserves the right to recover claim payments made on your or your dependent's behalf where the claim results from or is related to an injury or illness that is the responsibility of a third party. You are obligated to reimburse the Fund in full for any claims paid relating to such injury or illness. If you recover any amount from a third party and fail to repay the Fund for the claims it has paid, the Fund deducts the amount paid from any of your future benefit claims as an offset.

What is a third party and when are they responsible for your injuries or illness? Here are some examples:

- If you are in an auto accident and the other driver is at fault, the third party is the other driver and his or her insurance company.
- If you are in an auto accident and the other driver is uninsured, your auto insurance policy's 'uninsured motorists' provision is a third party for this purpose.
- If you are injured in an auto accident and covered under a "no fault" provision of your own insurance policy, your policy is the third party.
- If you are injured on the job, your employer's workers' compensation policy is the third party.
- If you fall in a store because there was a spill near a shelf that no one bothered to clean up, the store is the third party

The Fund pays claims for expenses incurred because of an illness or injury for which a third party is (or may be) responsible, but by submitting the claim for payment by the Fund you (and a covered Dependent if he or she suffers the illness or injury) are deemed to agree to each of the following conditions:

- That the Fund has an equitable lien on any recovery received by you, your dependent, legal representative, agent or any individual or entity who is in receipt of your recovery on your behalf.
- That you will notify any third party responsible for your illness or injury of the Fund's equitable lien and right to reimbursement for any claims related to your illness or injury.
- That you will hold any reimbursement or recovery received by you (or your dependent, legal representative or agent) in trust on behalf of the Fund to cover all benefits paid by the Fund with respect to such illness or injury and to reimburse the Fund promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss.
- That the Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person, that the Plan's claim has first priority over all other claims and rights, and that the make whole doctrine is not applicable to reduce the amount recoverable by the Fund.
- That you will reimburse the Fund in full up to the total amount of all benefits paid by the Fund in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Fund as reimbursement up to the full amount of the benefits paid.
- That the Fund's equitable lien and claim are not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise.
- That, in the event you elect not to pursue your claim(s) against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims.
- To assign, upon the Fund's request, any right or cause of action to the Fund.
- Not to take or omit to take any action to prejudice the Fund's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Fund in obtaining reimbursement.
- To forward any recovery to the Fund within ten days of disbursement by the third party or to notify the Fund as to why you are unable to do so.
- To permit the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Fund's attorney's fees and costs.

If you or your dependents have uninsured motorist or under-insured motorist coverage under an automobile liability insurance policy that applies to an illness or injury caused or contributed to by a third party, the conditions described above also apply to your rights under that insurance policy.

If you or your dependents fail or refuse to assist Fund representatives in recovering damages from a third party, then the Fund may:

- Offset what is paid on your and your dependents' future benefits claims until the Fund is completely reimbursed for the cost of these claims, including but not limited to costs incurred in collection;
- File a lawsuit against you or your dependents to fully recover the amount the Fund should have been reimbursed, and
- Take any other action deemed appropriate by the Board of Trustees.

If you or your dependents do not receive payments from a third party for an illness or injury caused by the third party, you do not have to pay the Plan back for any benefits properly paid to you or your dependents. If you do receive payment from the third party, you do not have to pay the Plan more than the amount the third party paid to you or your dependents.

If you have questions about how to comply with these third party liability rules, contact the Administrative Office.

GENERAL EXCLUSIONS AND LIMITATIONS

This section provides information on exclusions and limitations that apply to all Fund benefits.

The separate sections of this Benefits Booklet also describe additional exclusions and limitations that apply to the particular benefits.

*This section explains the treatments and expenses that the Plan **does not cover.** In other words, these treatments and expenses are **excluded** from the Plan. You are responsible for paying any of the following excluded expenses. In addition to the general exclusions listed below, each type of group coverage has additional exclusions that are specific to that coverage. These specific exclusions are listed in the sections that explain each type of coverage (e.g., medical, dental, etc.). The exclusions below do not apply to life insurance, but do apply to all other group coverages.*

In addition to the exclusions already discussed in each benefit section, the Plan pays no benefits for the following:

1. Treatment that is not medically necessary.
2. Any accidental bodily injury caused by or occurring in the course of the eligible person's employment, or in connection with illness or disease for which the person is entitled to benefits from Workers' Compensation or similar law.
3. To the extent permitted by federal or state law, any condition for which care or treatment is obtained from a federal government agency or from any state or political subdivision where this care is available without cost to the individual. To the extent permitted by federal law, any period of confinement in, or any medical care and treatment received from a Veterans Administration Hospital, except where coordination of benefits is required for treatment of a non-service connected disability. In addition, any confinement or care in a hospital owned or operated by a state or political subdivision is excluded from coverage, unless there is an unconditional requirement to pay for this care or confinement without regard to the rights of others, contractual or otherwise.
4. Any medical or dental services or supplies provided by or paid for by any governmental program (national, state, county, district or municipal).
5. Charges for treatment of accidental bodily injury or sickness that occurs while in the armed services and determined by the Secretary of Veterans Affairs to be service connected.
6. Charges for treatment of bodily injury or sickness that resulted from an act of war, declared or undeclared, including armed aggression.
7. The Plan will not pay any expenses the participant is not obligated to pay, such as expenses incurred under HMO coverage for which no charge would otherwise be made to the patient.
8. Conditions caused by or resulting from your commission of an illegal act or an act of personal aggression. Provided, however, that this exclusion will not apply if the injury or condition resulted from an act of domestic violence or a mental health condition, to the extent that treatment for the injury or condition would otherwise be covered.
9. Services or supplies provided without charge, or for which the individual does not have to pay.
10. Professional services provided by a person who lives in the covered individual's home or is related to the individual by blood or marriage

11. Any service, supply, or treatment (including hospital stays) that was rendered or furnished before the patient became covered by the Plan or after the individual is no longer eligible to receive benefits under the Plan.

12. Charges for any treatment of bodily injury or sickness that is intentionally self-inflicted. Provided, however, that this exclusion will not apply if the injury or condition resulted from a mental health condition, to the extent that treatment for the injury or condition would otherwise be covered.

13. Expenses incurred for a plan participant who lives outside the United States.

14. Expenses resulting from your failure to comply with primary carrier's plan requirements in circumstances where benefits are being coordinated with another group health plan.

GENERAL AND ADMINISTRATIVE INFORMATION

In this section you will find important information on:

- Administration of the Fund
- Funding of benefits
- The Board of Trustees

This section provides you with important information about the Bay Area Automotive Group Welfare Fund and Plan.

NAME OF PLAN

The name of your Bay Area Automotive Group Welfare Fund benefit plan is contained in the title of your Benefit Insert.

PLAN ADMINISTRATOR

The Plan is administered by the joint Board of Trustees of the Bay Area Automotive Group Welfare Fund, which contracts for administrative services with:

Health Services & Benefit Administrators
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
1 (800) 267-3232
www.baag.org

EMPLOYER IDENTIFICATION NUMBERS AND PLAN NUMBER

The Fund's "employer identification number" for tax purposes is EIN 94-6072964. The plan number is 501.

TYPE OF PLAN AND FUNDING ORGANIZATION

This is a welfare plan that provides medical, surgical and hospital, prescription drug benefits, dental benefits, vision care benefits, short-term disability benefits and group life and accidental death and dismemberment insurance.

The Plan is funded by monthly contributions from Participating Employers paid on behalf of eligible employees and their eligible dependents. The amount of the contribution is determined by the Board of Trustees of the Bay Area Automotive Group Welfare Fund acting under the authority of the Collective Bargaining Agreements. Assets of the Plan are held in trust, and benefits are funded through the Bay Area Automotive Group Welfare Fund. Eligibility for benefits under the Plan (except in circumstances where you are entitled to extended coverage) depends on continued receipt of employer contributions on your behalf. If your employer stops making contributions, you lose your eligibility for benefits. In addition, the Trust's obligation to provide benefits is limited to the extent the Bargaining Agreements provide for funding of the Trust sufficient to provide benefits.

The Self-Funded Medical (including TAP), Prescription Drug and Dental Plans and Short-Term Disability Plan are funded directly by the Bay Area Automotive Group Welfare Fund. These benefits are not insured by any contract of insurance and there is no liability on the Trustees or any other individual or entity to

provide payment over and beyond the amounts in the Bay Area Automotive Group Welfare Fund collected and available for such purpose.

HMO and DMO coverage, vision care benefits and life insurance and AD&D benefits are funded through contracts between, respectively, Kaiser, the DMOs, VSP and Prudential Insurance. Under these contracts, these providers assume the risk for payment of claims.

TYPES OF BENEFITS

All of the types of benefits provided by insurance policies, service agreements or the Plan are summarized in this Benefits Booklet. The complete terms of the benefits provided are set forth in the group insurance policies or service agreements with the following organizations:

Medical

Anthem Blue Cross
21215 Burbank Blvd.
Woodland Hills, CA 91367
1 (800) 274-7767
Provides network of medical providers, pre-admission certification and utilization review

Kaiser Foundation Health Plan, Inc.
Member Service Office
2425 Geary Blvd.
San Francisco, CA 94115
1 (800) 464-4000
Prepaid medical HMO insured by Kaiser Permanente

Dental

Bright Now! / Newport Dental
100 Spectrum Center Drive, Suite 1500
Irvine, CA 92618
1 (800) 497-6453

AND

DeltaCare USA
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703
1 (800) 801-7105
DeltaCare USA provides dental services through a network of participating dentists

AND

UnitedHealthcare Dental
2300 Clayton Road, Suite 1000
Concord, CA 94520
1 (800) 999-3367
UnitedHealthcare Dental provides dental services through a network of participating dentists

Prescription Drugs

OptumRx
OptumRx Claims Department
PO Box 650629
Dallas, TX 75265-0629
(800) 356-3477

Vision Care

Vision Service Plan (VSP)
P.O. Box 385018
Birmingham, AL 35238-5018
1 (800) 877-7195

Alcohol and Drug Dependency Assistance

Teamsters' Assistance Program
80 Swan Way, Suite 320
Oakland, CA 94621
1 (510) 562-3600
1 (800) 253-8326 (Outside SF Bay Area)

Life, Accidental Death & Dismemberment

Prudential Insurance Co. of America
Group Life Claims Division
P.O. Box 8517
Philadelphia, PA 19101
1 (800)-524-0542

AGENT FOR SERVICE OF LEGAL PROCESS

The person designated as Agent for Service of legal process is:

Paul Lai
Health Services & Benefit Administrators
4160 Dublin Blvd, Suite 100
Dublin, CA 94568

Legal process may also be served on any current member of the Board of Trustees.

SOURCES OF PLAN CONTRIBUTIONS

The contributions necessary to finance the Plan are made by the Employers sponsoring the Plan and Welfare Fund pursuant to the terms of their Collective Bargaining Agreements with participating Unions. A complete list of the Employers and Unions sponsoring the Plan may be obtained upon written request to the Administrative Office and is available for inspection at the Plan's Administrative Office. Some Collective Bargaining Agreements may also require participating employees to contribute to the cost of

coverage under certain circumstances. Assets of the Welfare Fund are held in Trust and benefits are funded through the Trust.

DATE PLAN YEAR ENDS

The Plan Year ends on November 30.

COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to one or more Collective Bargaining Agreements. A copy of any such agreement may be obtained upon written request to the Administrative Office and is available for examination at the Administrative Office during regular business hours.

TRUSTEES OF THE PLAN

The names, titles and business addresses of the Trustees of the plan are as follows:

EMPLOYER TRUSTEES

Glenn Berkheimer
Industrial Employers & Distributors Association (IEDA)
2200 Powell Street, Suite 1000
Emeryville, CA 94608

Jason Finch
SP+
P.O. Box 280567San Francisco, CA 94128

Open Seat

UNION TRUSTEES

Tony Delorio
Teamsters Local 665
150 Executive Park Blvd., Suite 4400
San Francisco, CA 94134

Juan Gallo
Teamsters Local 665
150 Executive Park Blvd., Suite 4400
San Francisco, CA 94134

Florencio Sinogui
Teamsters Local 665
150 Executive Park Blvd., Suite 4400
San Francisco, CA 94134

FUTURE OF THE WELFARE FUND

The Bay Area Automotive Group Welfare Fund and this Plan are maintained through collective bargaining. The Board of Trustees anticipates that the Plan will continue so long as Collective Bargaining Agreements so provide or until the bargaining parties elect to discontinue the Welfare Fund or Plan. The Board of Trustees reserves the right to change or modify the Plan at any time for any reason without specific approval of any person. Any change or modification of the Plan will not affect a claim incurred by a covered person before the effective date of such change or modification. If the Welfare Fund or Plan is terminated, the remaining assets will be used to continue to provide benefits under the Plan until there are no assets remaining or will be used in a manner consistent with the purpose of the Plan. In no event will termination of the Welfare Fund or Plan result in a reversion of assets to any Employer.

There is no guarantee of Plan benefits. There is no liability on the part of the Board of Trustees to provide payment over and above the amounts collected and available for such purposes. The Trustees reserve the right to change or discontinue the types and amounts of benefits and the eligibility rules described in this Benefits Booklet and the related Benefit Insert in any manner in which they, in their sole discretion, determine to be prudent. The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

DISCRETIONARY AUTHORITY OF THE BOARD OF TRUSTEES

The Trustees shall be the named fiduciaries with the absolute discretionary authority to control and manage the operation and administration of the Plan and to interpret or construe all provisions of the Plan, including the discretionary authority to determine eligibility for benefits. These fiduciaries shall be deemed to have properly exercised their authority unless they have abused their discretion hereunder by acting arbitrarily or capriciously. The Trustees shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Trustees may deem appropriate. The rules, interpretations, computations and actions of the Trustees shall be binding and conclusive on all persons. In administering the Plan, the Trustees shall at all times discharge their duties with respect to the Plan in accordance with the standards set forth in section 404(a)(1) of ERISA.

Without limiting the foregoing, the Trustees shall have the sole and absolute discretionary authority:

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

All determinations made by the Trustees with respect to any matter arising under the Plan, this Summary Plan Description, and any other Plan documents shall be final and binding on all parties.

PERFORMANCE OF DUTIES AND RESPONSIBILITIES

The Trustees may engage such attorneys, actuaries, accountants, consultants or other persons to render advice or to perform services with regard to any of its responsibilities under the Plan as it shall determine to be necessary or appropriate. The Trustees may designate by written instrument (signed by both parties) one or more actuaries, accountants, administrative service organizations or consultants as fiduciaries to carry out, where appropriate, fiduciary responsibilities of the Trustees. The Trustees may rely on the actions of an administrative service organization or the written opinion or advice of counsel or any actuary prudently retained by the Trustees.

NOT WORKERS' COMPENSATION

The group policy is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance. The Plan will not pay benefits for any accidental bodily injury caused by or occurring in the course of the eligible person's employment, or in connection with illness or disease for which the person is entitled to benefits from Workers' Compensation or similar law. However, the Plan may provide provisional coverage subject to a lien against any Workers' Compensation benefits ultimately awarded. In the event that you or a covered dependent sustain a work-related injury and file any claims with the Plan related to that injury, the Plan conditions any payment of such claims on its right to recover any monies it has paid from for these claims from any workers' compensation judgment, award, or settlement of any kind as described under the "Right of Reimbursement and Third Party Liability" provision on page 93 of this Benefits Booklet.

BENEFITS EXEMPT FROM ATTACHMENT

To the full extent permitted by law, all rights and benefits under the group policy are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any insured or any beneficiary. However, notwithstanding this provision, the Trustees shall be entitled to offset against further claims as provided in the "Right to Information, Payment and Recovery of Payment" provisions found on page 93 and in "If You Claim Coverage for Someone Who Is Not Eligible" provisions on page 9 of this Benefits Booklet.

YOUR HEALTH INFORMATION AND PRIVACY

The health benefit options offered under the Plan use health information about you and your covered dependents only for the purposes of providing treatment, paying claims, and related functions. Refer to the HIPAA Privacy Notice and Rule beginning on page 105 of this Benefits Booklet.

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

YOUR FEDERAL RIGHTS UNDER ERISA & HIPAA

In this section you will find information on your rights under two important federal laws:

ERISA

HIPAA

STATEMENT OF ERISA RIGHTS

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

- Receive information about your Plan and benefits.
- Examine, without charge, at the Administrative Office, all plan documents, including insurance contracts, 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 Plan Administrator, 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 updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or other 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.

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

If you have coverage provided through an HMO, state law minimum benefit requirements will also apply. For example, under California law, your HMO may be required to cover a follow-up visit within 48 hours of discharge when prescribed by a physician. Please also refer to your HMO materials for additional information.

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. The claim fiduciary shall have the discretion to determine eligibility for benefits and to construe the terms of the plan. 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 Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

HIPAA PRIVACY NOTICE AND RULE

USE AND DISCLOSURE OF HEALTH INFORMATION

The Bay Area Automotive Group Welfare Fund ("Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the

Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

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

The Plan may also disclose to your spouse, family member, or your personal representative, your health information for purposes of making or obtaining payment and care. Prior to doing so, the Plan will seek your oral agreement. If the Plan is not able to obtain your oral agreement, it will exercise professional judgment in determining whether speaking with someone regarding your health information based on the circumstances is in your best interest. If you wish the Plan not to release your health information to your spouse, family member or personal representative without a written authorization, please follow the instructions under the Right to Request Restrictions, found in this notice. Your request in this matter will be followed.

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

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

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

For distribution of health-related benefits and services. The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

Public health risks. The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

For disclosure to the plan sponsor. The Bay Area Automotive Group Welfare Fund is a jointly trusteed multiemployer trust fund that contracts with a third-party administrator for the day-to-day administration of the Plan. The Fund's Board of Trustees – not your employer or union – is the Plan Sponsor. The Plan Sponsor itself has no employees. The Plan Sponsor contracts with a third-party administrator to administer the Plan. As Plan Sponsor, the Board of Trustees represents that adequate separation exists between the Plan and Plan Sponsor so that protected health information will be used only for plan administration. The Plan may disclose your health information to the Plan Sponsor for administration functions performed by the Board of Trustees on behalf of the Plan, as described in 45 C.F.R. § 164.504(a), to the extent permitted under HIPAA regulations. Such administration shall include, but is not limited to, the following purposes: appeals of adverse benefit determinations, arranging for legal services, financial oversight, data analysis, COBRA administration, coordination of benefits, and plan design. The Plan also may provide summary health information to the Plan Sponsor so that the Plan Sponsor may solicit premium bids from other health plans or modify, amend or terminate the Plan. The Board of Trustees will not use or further disclose your PHI other than as permitted or required by applicable law. The Plan will not use or disclose your PHI for marketing purposes or in exchange for payment.

As a condition for obtaining protected health information from the Plan and other insurers and HMOs participating in the Plan, the Plan Sponsor shall:

- Use or disclose protected health information received from the Plan only as permitted by the Privacy Rule or as required by law.
- Require each of its subcontractors or agents to whom the Plan Sponsor may provide protected health information to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to protected health information.
- Bar the use or disclosure of protected health information for employment-related actions or decisions or in connection with any other plan of benefits or employee benefit plans sponsored by the Plan Sponsor.
- Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your protected health information available at your request for inspection or copying.
- Make protected health information available to the Plan to permit you to amend or correct protected health information contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as permitted by HIPAA.
- Make available the information required to provide an accounting of disclosures in accordance with HIPAA.
- Make its internal practices, books and records relating to the use and disclosure of protected health information available to the Plan and to the Secretary of the U.S. Department of Health and Human Services ("DHHS") for the purpose of determining the Plan's compliance with HIPAA.
- If feasible, return to the Plan or destroy all protected health information received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Plan Sponsor

agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

- Use best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which the information is requested.

When legally required. The Plan will disclose your health information when it is required to do so by any federal, state, or local law.

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

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

In connection with judicial and administrative proceedings. As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you or, to the extent you or your representative can not be notified, to seek an order protecting your health information.

For law enforcement purposes. As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To coroners, medical examiners and funeral directors. The Plan may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release your health information to funeral directors as necessary to carry out their duties.

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

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

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

Authorization to Use or Disclose Health Information

Other than as stated above, the Plan will not disclose your health information other than with your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

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

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

Right to inspect and copy your health information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer at the Plan's Administrative Office. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

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

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

Right to a paper copy of this notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Officer at the Plan's Administrative Office.

DUTIES OF HEALTH PLAN

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to

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

CONTACT PERSON

The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Officer at:

Bay Area Automotive Group Welfare Fund
Health Services & Benefit Administrators
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
1 (800) 267-3232

EFFECTIVE DATE

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