

OFFICE & PROFESSIONAL EMPLOYEES INTERNATIONAL

UNION LOCALS 30 & 537

HEALTH & WELFARE FUND

SUMMARY PLAN DESCRIPTION

REVISED EFFECTIVE JANUARY 1, 2008

To All Plan Participants:

We are pleased to provide you with this new booklet which describes the Fund's eligibility rules and benefits for active members and their families. This booklet includes all changes made through January 1, 2008. **Please review this booklet thoroughly to familiarize yourself with the latest changes.**

This booklet contains descriptions of all the benefits provided by the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund except for health benefits under the Kaiser Foundation Health Plan and dental benefits through United Concordia. Benefit programs under Kaiser and United Concordia are explained in separate booklets issued by these organizations.

We hope that these benefits will protect you and your family members if any of you suffer illness or injury. We also hope that you will use your health benefits intelligently, taking advantage of the preferred provider discounts and following the rules requiring pre-certification of hospital stays and other cost containment features. By doing so, you will qualify for maximum benefits. At the same time, you will help the Fund operate in the most cost effective way possible.

In the pages that follow you will find a summary of benefits, the rules covering eligibility for those benefits, and the procedures that should be followed when making a claim. Contained in the back of the booklet is additional information about the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund as required by law. We also encourage you to visit the Trust website at www.opeiufunds.org.

Only the Board of Trustees is authorized to interpret the rules and regulations described in this booklet. No individual Trustee, union representative, or employer representative is authorized to interpret the rules and regulations on behalf of the Board or to act as an agent of the Board.

The Board of Trustees has authorized the Plan Administrator to respond in writing to written inquiries from Fund Participants. As a convenience to you, the Plan Administrator may provide oral answers regarding coverage on an informal basis. However, no such oral communication is binding on the Board of Trustees.

Again, we strongly suggest that you read the entire contents of this booklet so that you will be familiar with the comprehensive protection the Fund provides you and your family. You may call the Plan Administrator at (562) 463-5065 or (800) 386-4350 should you have any questions.

THE BENEFITS SUMMARIZED MAY OR MAY NOT WHOLLY APPLY TO YOU SINCE THE AGREEMENT BETWEEN YOUR EMPLOYER AND THE UNION MAY PROVIDE FOR ALL OR JUST SOME OF THE BENEFITS DESCRIBED.

Sincerely,

THE BOARD OF TRUSTEES

INTRODUCTION

This Fund was established as a result of collective bargaining between representatives of your Employer and Office and Professional Employees International Union Local 30 and Local 537. Contributions are paid by your Employer into a Trust Fund to provide Medical, Surgical, Hospital, Dental, Prescription Drug, Life and AD&D insurance and Vision Benefits for employees and their dependents.

HOWEVER, THE AGREEMENT BETWEEN YOUR EMPLOYER AND THE UNION MAY PROVIDE FOR ALL OR JUST SOME OF THE BENEFITS LISTED HEREIN.

The Board of Trustees determines policies and benefits in keeping with the assets and income of the Office and Professional Employees Locals 30 & 537 Health and Welfare Trust Fund. Benefits are subject to all of the terms and conditions of the Trust Agreement as well as to any rules and regulations the Trustees may adopt from time to time.

This booklet describes how you and your dependents may use these Benefits to the best advantage, when you are eligible. Please read it carefully and if you have any questions, contact the Trust Fund Office.

IMPORTANT NOTICE TO EMPLOYEES, SPOUSES AND DEPENDENTS

From time to time the Trust Fund Office may mail you updated materials in order to inform you and your dependents of any changes in benefits. It is important that you file all literature received in the back of this booklet and note the affected sections.

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

1. To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
2. To formulate, interpret and apply rules, and policies necessary to administer the Plan in accordance with its terms;
3. To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
4. To resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents; and
5. 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.

IMPORTANT PHONE NUMBERS

In many cases, you will receive better health benefits from the Plan if you make informed decisions. If you have any questions about how to use the Plan, contact the Trust Fund Office for assistance. Important phone numbers and websites are listed below.

For general information about the Plan or for information about eligibility, benefits or claims:

Plan Administrator/Trust Fund Office (BPA)

13191 Crossroads Parkway North, Suite 205

City of Industry, California 91746

(562) 463-5065 or

(800) 386-4350

www.opeiufunds.org

For information about Major Medical Plan Panel Providers:

First Health (formerly CCN)

(888) 685-7774

www.firsthealth.com

For information about Major Medical Plan Panel Providers when traveling outside the First Health service area:

MULTIPLAN

(800) 557-6794

www.multiplan.com

For information about Major Medical Plan Pre-Admission Review:

First Health

(800) 528-7936

In case of a Major Medical Plan emergency admission (a call must be made within 48 hours of the emergency admission):

First Health

(800) 528-7936

For information about Kaiser HMO medical, prescription drug or vision benefits or provider locations:

Kaiser Foundation Health Plan, Inc.

(800) 464-4000

www.kaiserpermanente.org

For information about the vision program for Major Medical Plan participants:

Vision Service Plan

(800) 877-7195

www.vsp.com

For information about the Prescription Drug plan for Major Medical Plan participants:

Express Scripts

(888) 201-5853 or

(800) 243-9800

www.express-scripts.com

For information about the Pre-Paid Dental plan:

United Concordia

(866) 357-3304

www.unitedconcordia.com

For information about the life and AD&D insurance carrier:

Unimerica

(866) 615-8727 or

(866) 293-1794

www.unimerica.com

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USING YOUR HEALTH PLAN

The plan of medical benefits available through the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund allows the covered employee to choose, once each year, coverage under the Major Medical Plan, which allows you free choice of any physician you wish, or the Kaiser Foundation Health Plan, which provides full medical care for you and your dependents at any of its facilities.

If you choose to be covered under the Major Medical Plan, the Fund has contracted with a panel of physicians and hospitals through First Health (formerly known as CCN) which provide substantially increased benefits to you and your dependents. Please keep in mind that you have a choice of doctors and hospitals at all times. You will, however, save substantial out-of-pocket expenses by utilizing the First Health panel of providers.

It is important to note that even if you are utilizing the services of a First Health panel hospital, increased coverage for any physician charge is only available if the physician (including the assistant surgeon and anesthesiologist) is also a member of the First Health panel.

A summary of the Major Medical Plan (both open and panel) and Kaiser medical benefits available to you follows. A more detailed description of the benefits available to you under the Major Medical Plan is included in this booklet. Please be sure to thoroughly review the Major Medical Plan's cost containment programs administered by First Health starting on page 42. A separate brochure is available which describes the medical, prescription drug and vision benefits under the Kaiser Foundation Health Plan.

An option is also available to you for dental coverage. A description of the dental benefits under the "Basic Dental Plan" is included in this booklet. This option allows you to use the services of any licensed dentist. A separate brochure is available which describes greater coverage under the pre-paid dental option through United Concordia.

SPECIAL NOTICE TO KAISER ENROLLEES

Enclosed in this booklet is a brief summary of the medical, prescription drug and vision benefit coverage afforded to you and your dependents, if eligible. It is important to note that it is in summary form only and it does not completely describe your benefit coverage. For details on your Kaiser benefit coverage, please refer to the Kaiser Foundation Health Plan, Inc., Evidence of Coverage. The Evidence of Coverage is the binding document between the Kaiser Foundation Health Plan, Inc. and its members (or enrollees). A Kaiser Health Plan physician must determine that the services and supplies are medically necessary to prevent, diagnose or treat your medical condition. The services and supplies must be provided, prescribed, authorized or directed by a Kaiser Health Plan physician. You must receive the services and supplies at a Kaiser Health Plan facility or skilled nursing facility inside the Kaiser Service Area, except where specifically noted to the contrary in the Kaiser Health Plan Evidence of Coverage. For details on the benefit and claims review and adjudication procedures, please refer to the Kaiser Health Plan Evidence of Coverage. If there are any discrepancies between benefits provided in the summary and the Kaiser Health Plan Evidence of Coverage, the Kaiser Health Plan Evidence of Coverage will prevail.

SPECIAL NOTICE TO UNITED CONCORDIA ENROLLEES

For details on your benefit coverage, please refer to the United Concordia Evidence of Coverage. The United Concordia Evidence of Coverage is the binding document between United Concordia and its members (or enrollees). A provider in the United Concordia network must determine that the services and supplies are necessary to prevent, diagnose or treat your dental condition. The services and supplies must be provided, prescribed, authorized or directed by a provider in the United Concordia network. You must receive the services and supplies at an office within the United Concordia network of providers unless noted to the contrary in the United Concordia Evidence of Coverage. For details on the benefit and claims review and adjudication procedures, please refer to the United Concordia Evidence of Coverage. If there are any discrepancies between information provided herein and the United Concordia Evidence of Coverage, the United Concordia Evidence of Coverage will prevail.

O.P.E.I.U. LOCALS 30 & 537 HEALTH & WELFARE FUND HEALTH PLANS SUMMARY

COVERAGE AND TERMS	O.P.E.I.U. LOCALS 30 & 537 MAJOR MEDICAL PLAN
Explanation of Plans and Options Available to you:	You may use the doctor of your choice. When your claim is received, it is processed SUBJECT TO THE ANNUAL PLAN DEDUCTIBLE AND MAJOR MEDICAL PLAN LIMITATIONS AND EXCLUSIONS under the Major Medical coverage shown below.
INDIVIDUAL DEDUCTIBLE STOP LOSS MAXIMUM LIFETIME MAXIMUM	\$600 per person per calendar year. Maximum \$1,800 per family. When a participant incurs \$4,000 out-of-pocket for covered expenses during any calendar year; coverage will increase to 100%. Non-Panel hospital charges do not apply. \$1,000,000
HOSPITAL INPATIENT CARE: (Room accommodation on all options is <i>Semi Private</i>) Room and Board Intensive Care; C.C.U. Miscellaneous Hospital Charges EMERGENCY ROOM SKILLED NURSING FACILITY (Licensed) OUTPATIENT FACILITY CHARGES AMBULANCE	NOTE: PRE-NOTIFICATION PRIOR TO ANY NON-EMERGENCY HOSPITAL ADMIT IS REQUIRED (Call: 1-800-528-7936). 30% penalty for non-compliance. 60% -Semi-private room 60% - Maximum 2.5 x semi-private room 60% 60% 60% - Limited Benefits 60% 60% of Usual, Customary and Reasonable charges (UCR)
SURGICAL BENEFITS: Surgeon Assistant Surgeon Anesthetist	PRE-NOTIFICATION REQUIRED ON CERTAIN ELECTIVE SURGERIES CALL: 1-800-528-7936 - 30% PENALTY FOR NON-COMPLIANCE 60% - UCR 60% - UCR (up to 20% of Surgery charges, subject to medical necessity.) 60% - UCR
PHYSICIAN'S VISITS - IN HOSPITAL PHYSICIAN'S CARE - IN OFFICE Referred to Specialist Injectable Medications Radiation Therapy Physical Therapy X-Ray and Laboratory Podiatry Allergy Testing & Antigen Extract IN/OUT PATIENT PSYCHIATRIC CARE FAMILY PLANNING: Maternity, abortion and sterilizations ANNUAL HEALTH ASSESSMENT DURABLE MEDICAL EQUIPMENT	60% UCR 60% UCR 60% UCR 60% UCR 60% UCR 60% UCR - \$1,500 maximum per calendar year 60% UCR - Certain diagnostic tests must be pre-authorized. Call: 1-800-528-7936 - 30% penalty for non-compliance. 60% of \$75/visit; includes all services, 10 visits per calendar year. Limited to \$500 per calendar year. 60% UCR; limited to one visit per day; 50 visits per calendar year. Covered as any illness. 60% of UCR to \$150. 60% of UCR - up to purchase price.
PRESCRIPTION DRUGS	Through Express Scripts you pay \$15 for generic and \$25 for brand name prescriptions (limitation of 100 units or one month supply). 90-days supply available through Express Scripts mail order program at \$30 for generic and \$50 for brand name. After \$600 Major Medical deductible satisfied, will pay 60% of covered charge from non-participating pharmacy.
VISION BENEFITS	Through Vision Service Plan (VSP) with a \$25 exam copay and an additional copay of \$50 for frames and lenses. Exam - Once every 12 months Lenses - Once every 24 months Frames - Once every 24 months
	UCR - Usual, customary and reasonable as determined by the Plan.

<p style="text-align: center;">FIRST HEALTH NETWORK AVAILABLE UNDER MAJOR MEDICAL PLAN Must Utilize Participating FIRST HEALTH Hospitals and Providers</p>	<p style="text-align: center;">KAISER</p>
<p>May be used by participants covered under the Major Medical Plan at their option at any time. If a First Health Provider is used, the coverage shown below will apply SUBJECT TO THE ANNUAL PLAN DEDUCTIBLE AND MAJOR MEDICAL PLAN LIMITATIONS AND EXCLUSIONS.</p>	<p>For benefits through this plan you must use KAISER facilities.</p>
<p>\$300 per person per calendar year; maximum \$900 per family. When a participant incurs \$4,000 out-of-pocket for covered expenses during any calendar year, coverage will increase to 100%. See Major Medical Plan Option.</p>	<p>None None Unlimited</p>
<p>NOTE: PRE-NOTIFICATION PRIOR TO ANY <i>NON-EMERGENCY</i> HOSPITAL ADMIT IS REQUIRED (Call: 1-800-528-7936). 30% penalty for non-compliance. 80% 80% 80% 80% 80% - Limited Benefits 80% See Major Medical Plan Option</p>	<p>AT KAISER HOSPITALS ONLY - \$500 Admission Copayment</p> <p>\$50 copay per visit (waived if admitted) 100% - up to 100 days per year</p> <p>No charge within service area</p>
<p>PRE-NOTIFICATION REQUIRED ON CERTAIN ELECTIVE SURGERIES CALL: 1-800-528-7936 - 30% PENALTY FOR NON-COMPLIANCE 80% - UCR 80% - UCR (up to 20% of Surgery charges, subject to medical necessity.) 80% - UCR</p>	<p>THROUGH KAISER PHYSICIANS ONLY</p> <p>\$30 outpatient copay, \$0 inpatient copay 100% - YOU PAY NOTHING 100% - YOU PAY NOTHING</p>
<p>80% UCR 80% UCR 80% UCR 80% UCR 80% UCR 80% UCR - \$1,500 maximum per calendar year 80% UCR - Certain diagnostic tests must be pre-authorized. Call: 1-800-528-7936 - 30% penalty for non-compliance.</p> <p>80% of \$75/visit; includes all services, 10 visits per calendar year. Limited to \$500 per calendar year.</p> <p>80% UCR, limited to one visit per day, 50 visits per calendar year. Covered as any illness. 80% of UCR to \$150. 80% UCR - up to purchase price.</p>	<p>100% - YOU PAY NOTHING \$30 per visit payable prior to time of appointment. (\$5 for pre-natal and well-child preventive visits to age 2).</p> <p>\$30 copay per individual outpatient visit, \$15 for group visits (\$0 for inpatient).</p> <p>\$30 copayment. Covered according to Kaiser formulary - No copayment</p>
<p>See Major Medical Plan Option</p>	<p>You pay \$15 for generics and \$30 for brand name drugs (up to a 100-day supply).</p>
<p>See Major Medical Plan Option</p>	<p>Kaiser Facilities provide Vision Care. \$30 copay for eye exam. Lenses - Once every 24 months. Frames - Once every 24 months, An allowance of up to \$150 will be applied towards lenses and frames (or contact lenses).</p>
<p>UCR - Usual, customary and reasonable as determined by the Plan.</p>	

SCHEDULE OF BENEFITS

	Non-Panel	First Health Panel
EMPLOYEE AND DEPENDENT MEDICAL BENEFITS		
Deductible, per person per calendar year	\$ 600	\$ 300
Maximum deductible per family	\$ 1,800	\$ 900
(Deductibles do not apply to Annual Health Assessments, mammograms, immunizations or inoculations.)		
 Hospital Daily Benefit for Room and Board	 60% of Semi-Private rate	 80%
Intensive or Coronary Care	60% of 2½ times Semi-Private rate	80%
Miscellaneous Hospital Charges	60% of usual & customary charges	80%

NOTE: PRE-NOTIFICATION PRIOR TO ANY NON-EMERGENCY HOSPITAL ADMIT OR SURGERY IS REQUIRED. TO AVOID A 30% REDUCTION IN COVERAGE, YOU MUST COMPLY WITH THE PROVISIONS DESCRIBED IN THE COST CONTAINMENT PROGRAMS SECTION STARTING ON PAGE 42.

Extended Care or Skilled Nursing Facility Daily Rate (60 days maximum)

60% (80% if a panel provider) of the amount of Covered Expense incurred, *but not to exceed* 50% of the average semi-private room and board rate for hospitals in the area in which the convalescent hospital is located.

Major Medical Benefits (described on pages 35 through 41)

The Major Medical Benefits cover much of the cost of medical expense. Covered expenses include cost of doctors' visits, nursing care, x-rays, laboratory tests, surgery, and many other kinds of medical services and supplies (including charges for immunizations and inoculations). The Plan covers allowable charges up to a maximum of \$150 for an annual health assessment that will include routine Pap smears and prostate exams.

	Non-Panel	Panel
Percentage Payable	60% of usual & customary charges	80%
Medical Benefit Lifetime Maximum	\$1,000,000	

Covered Expense incurred for psychotherapy whether in or out of a hospital will be limited to 50 sessions in any calendar year.

In emergency situations only, non-panel hospital charges will be paid at panel coverage percentages until the patient can be safely transferred to a panel hospital. The cost of the transfer will be paid at 100% of usual, customary and reasonable charges. If, after the condition of the patient is stabilized and the patient does not wish to be transferred to a panel hospital, the Major Medical Plan will pay according to the non-panel percent coverage.

After a covered person has incurred out-of-pocket Covered Expenses totaling \$4,000 during any calendar year and after the Deductible Amount has been satisfied, the percentage payable for Covered Expense incurred during the balance of the calendar year will be 100% of Allowable Charges (does not apply to non-panel hospital or non-panel skilled nursing facility expenses).

EMPLOYEE AND DEPENDENT BASIC DENTAL PLAN EXPENSE BENEFITS

Annual Deductible	\$50
Percentage Payable (of Maximum Fee Allowance) including Covered Dental Expense incurred on account of Orthodontics	
Diagnostic and Preventive	100%
Basic Benefits (<i>i.e.</i> , fillings and oral surgery)	90%
Major Services (<i>i.e.</i> , crowns, bridges and dentures).....	90%

Pre-certification is required when services are expected to exceed \$500 (see page 44).

Maximum Dental Amount Per Covered Individual

Orthodontics (lifetime maximum)	\$2,000
Other Dental Expense (calendar year maximum).....	\$2,000

EMPLOYEE AND DEPENDENT PRESCRIPTION DRUG BENEFITS - THROUGH EXPRESS SCRIPTS

Copayment Amount	\$15 for generics/\$25 for brand name prescriptions filled at a participating Express Scripts Pharmacy. Mail service program copayments are \$30 for generics and \$50 for brand names.
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NOTE: Reimbursement will be limited to the cost of a generic if a generic is available when a brand name drug is dispensed unless the physician indicates "dispense as written (DAW)" on the prescription. Prescriptions not purchased using Express Scripts will be reimbursed at 60% of reasonable charges, subject to the \$600 Major Medical Plan deductible.

SUPPLY LIMITATION

Retail Program	30 Days
Mail Service Program.....	90 Days

EMPLOYEE AND DEPENDENT VISION CARE BENEFITS - THROUGH VISION SERVICE PLAN NETWORK OF OPTOMETRISTS AND OPHTHALMOLOGISTS

Copayment Amount	\$25 for exam \$50 for materials
Vision Exam	Every 12 months
Lenses	Every 24 months
Frames	Every 24 months

Limited benefits available from out-of-network providers.

EMPLOYEE ONLY LIFE INSURANCE BENEFITS	<u>AMOUNT</u>
Death Benefit	\$12,500
Accidental Death and Dismemberment (Additional)	\$12,500

PANEL PROVIDERS - (FIRST HEALTH)

The Major Medical Plan maintains an agreement with First Health providing for "Preferred Provider" rates for physician services and medical facilities. Because First Health providers have agreed to accept contractual rates, you benefit directly when you use First Health facilities and physicians.

Covered expenses are paid at 80% for First Health Panel medical facilities and physician charges (compared to 60% of usual, customary and reasonable charges for non-Panel providers).

For a list of First Health Panel physicians and network hospitals, please call the Trust Fund Office at (562) 463-5065 or First Health at (800) 226-5116. You may also visit the First Health website at www.firsthealth.com.

The list of Panel providers is subject to change. Before your initial appointment with a physician listed in the First Health directory, please call First Health to make sure that the physician is still a First Health provider.

Use of a First Health panel provider does not in itself guarantee eligibility or covered benefits. You must always maintain eligibility according to the Eligibility Rules starting on page 15 to be covered. Charges will only be paid for an eligible employee or dependent if the benefit is covered (see pages 35 through 37) and not limited or excluded (see pages 37 through 41).

If you live or are traveling outside the First Health service area, call MULTIPLAN at (800) 557-6794 should you require immediate medical care. MULTIPLAN will assist you in finding the nearest available contract provider.

PAYMENT OF MAJOR MEDICAL PLAN AND BASIC DENTAL PLAN BENEFIT CLAIMS

There are special procedures to follow when you need to file a claim. The procedures must be followed as outlined below, otherwise your claim may be denied. If you have any questions regarding the claims and review procedures, call the Trust Fund Office at (562) 463-5065 or (800) 386-4350.

If you are enrolled in the Kaiser HMO plan, please refer to the booklet or Evidence of Coverage (EOC) provided by Kaiser for information on claims and appeals procedures. If you are enrolled in the United Concordia dental plan, please refer to the United Concordia EOC for the claims and appeals procedures.

The Plan's claims procedures include administrative safeguards and processes designed to ensure and to verify that benefit claims determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated individuals.

How to File a Claim

1. Obtain a claim form from the Trust Fund Office or your Employer when you or your dependents have incurred Covered Expenses.
2. Complete the Employee portion of the claim form.
3. Have your doctor or dentist complete his/her portion of the claim form in detail.
4. Upon completion of the claim form return your claim form to:

O.P.E.I.U. LOCALS 30 & 537 HEALTH AND WELFARE FUND
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434
Phone: (562) 463-5065
(800) 386-4350

How Claims are Processed

Claim forms received in the Trust Fund Office are first examined to determine whether or not all pertinent information has been included. Claim forms containing all required information are processed by a Trust Fund Claims Examiner. A decision on your claim will be sent to you in writing within 15 days for a pre-service claim and within 30 days for a post-service claim after receipt of your claim. For urgent care claims, the decision will be rendered within 72 hours after receipt of your claim and may be provided to you orally with the written notice sent to you no later than 3 days after the oral notification. A description of the expedited review process will also be provided to you.

If all information necessary for processing has not been included, the Trust Fund Office will request additional information from you as follows:

1. Within 24 hours for any urgent claim for medical care or treatment that may jeopardize your life, health or ability to regain maximum function, or in the opinion of your physician could subject you to severe pain if care or treatment is not received promptly.
2. Within 5 days for any claim for a benefit that requires you to obtain approval before you receive medical care or treatment (pre-service claims).

3. Within 30 days for any claim for medical care or treatment that you have already received (post-service claims).

If additional information is requested from you, the time period for making a decision on your claim will be suspended for 45 days (48 hours for urgent care claims) from the date you are notified or until a response is received from you, whichever is earlier.

The time period for making a decision may also be extended an additional 15 days for pre-service and post-service claims if there are special circumstances beyond the control of the Trust Fund Office. You will be sent a written notice within the initial 15 days for pre-service claims and within the initial 30 days for post-service claims, if an extension is required.

If you fail to cooperate with such requests, your claim may be denied. If your claim is denied, in whole or in part, a notice of denial will be sent to you or your representative.

You may direct benefit payments to be made to the person or facility providing the medical care. Otherwise payment will be made directly to you if no such direction was made. An "advice of payment" is always sent to you, which shows the charges you submitted, the payments the Fund is able to allow and the balance, if any, which is your responsibility to pay.

Benefits will be paid only if notice of a claim is submitted within 90 days from the date expenses were incurred, unless the Employee can show it was not reasonably possible to give notice within that time limit. **However, in no event shall benefits be allowed if the claim is submitted beyond one year from the date on which expenses were incurred.**

Concurrent Care Claims

If you have any claim that results from the termination or reduction of previously granted benefits to be provided over a period of time, the Plan will notify you in advance of the termination or reduction to allow you time to appeal the decision and obtain a determination before the benefit is reduced or terminated.

Also included under this category are requests to extend the course of treatment beyond the initial prescribed period of time or number of treatments for urgent cases. In these situations, the Plan will inform you of the decision within 24 hours after receipt of the claim by the Plan, provided the claim is made to the Plan at least 24 hours before the expiration of the initially approved treatment. If such a claim were denied, it would be appealable as an urgent care claim.

Any request to extend a course of treatment that does not involve urgent care is a claim that is governed by the standards generally applicable to such claims.

All or Part of a Claim May be Denied

It is not unusual that some charges submitted for a particular claim may be denied. For instance, a person might use a private room which costs more than semi-private. The person might have charges on his hospital bill for TV and telephone calls. Such charges are denied, because they are not covered charges. Some claims submitted are not covered at all and in such cases, the reason for denial is sent to the employees involved. Common reasons for denial are:

1. The expenses were incurred during a month that the employee was not eligible.
2. The expenses were incurred as the result of an injury occurring on the job.

These are, of course, not all the possible reasons for denial. They are only examples of denials that occur quite frequently.

Claim Review Procedure

1. No participant, active or retired, dependent or beneficiary of either one or the other person shall have any right or claim to benefits other than as specified in such eligibility resolutions as the Trustees shall determine and establish. If any claimant shall have a dispute as to eligibility, type, amount or duration of such benefits, the dispute shall be resolved by the Board of Trustees, as hereinafter set forth.
2. Any person whose application for benefits has been denied in whole or in part shall be notified of such decision in writing. Such notice shall set forth the specific reason or reasons for the denial, contain specific references to pertinent provisions upon which the denial is based, describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary, include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim (these relevant documents include any information that was relied upon, submitted, considered or generated in the course of making the benefit decision); if an internal rule, guideline, protocol or other similar criterion was relied upon in making the claim determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request; if a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the claim determination, you will be provided with a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, will be provided to you free of charge upon request; and a description of the Plan's claim review procedures including a statement of your right to bring a civil action under section 502 (a) of ERISA if your claim on review is denied.

In the case of a denial on a claim involving urgent care:

The information described above and a description of the expedited review process for urgent care claims may be provided to you orally within 72 hours after receipt of your claim by the Plan. The written notice will be furnished to you not later than 3 days after the oral notification.

Expedited review process for urgent care claims:

A request for an expedited appeal for an urgent care claim may be submitted orally or in writing by you and all necessary information, including the Plan's benefit determination, will be transmitted to you by telephone, facsimile, or other available expeditious methods.

3. If you desire further consideration of the decision denying the claim, you may request a review upon written application to the Board of Trustees. In connection with such request for review, you or your authorized representative shall be entitled to submit issues and comments in writing to the Board of Trustees, which shall be considered in arriving at a decision on review.
4. Request for review shall state in clear and concise terms the reason or reasons for disagreement with the decision and shall be filed with the Trust Fund Office within 180 days after the date on which you receive the decision denying the claim. Failure to file a request for review within such 180-day period shall constitute a waiver of your right to a review of the decision and your right to file suit in a state or federal court. You must exhaust the Plan's administrative appeals procedures before you can file suit in a state or federal court.
5. Upon receipt of a request for review, the Board of Trustees shall review the administrative file, including the request for review at the Trust Fund Office. The Board of Trustees will review all submitted comments, documents, records and other information related to the claim, regardless of whether the information was submitted or considered in the initial claim decision. The Board of Trustees will not give deference to the initial claim decision.

6. If the claims denial is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. The health care professional will be an individual who is neither the individual consulted in connection with the initial claim decision nor the subordinate of such individual. The Board of Trustees will provide you with the identification of any medical or vocational expert whose advice was obtained in connection with a claims denial, without regard to whether the advice was relied upon in making the denial.
7. The claimant shall be advised of the decision of the Board of Trustees in writing, which shall include the specific reasons for the denial; reference to the pertinent Plan provisions on which the denial is based; a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; a statement of your right to bring a civil action under section 502 (a) of ERISA; if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request; if a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request; and a statement that you and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.
8. You will be informed of the decision on your request for review within 72 hours for an urgent care claim and within 30 days for a pre-service claim.

For post-service claims, the decision will be made by the Board of Trustees no later than the date of the meeting that immediately follows the receipt of the request for review by the Trust Fund Office. If the request for review is received within 30 days before the date of such meeting, the decision will be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances require further extension, the decision will be rendered not later than the third meeting of the Board of Trustees following receipt of the request for review. A written notice will be mailed to you prior to the extension. The Trust Fund Office will notify you of the decision as soon as possible, but not later than 5 days after the decision is made.

9. In performing its review of any claim, the Board of Trustees is expressly authorized to exercise its unrestricted discretion to interpret any provision of Plan documents, its rules or regulations, the Summary Plan Description, the Trust Agreement, and any other documentation relating to the Trust Fund or the claim.

DEFINITIONS

1. **Allowable Charges:** The term "Allowable Charge" means the customary charge, in the area in which it is incurred, but not exceeding such charge as would have been made in the absence of benefits provided under this Plan. A "customary charge" as used herein, means the usual charge made by a Hospital, Doctor, or other professional person, or other person or firm having rendered or furnished services, treatments or supplies which do not exceed the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred, for bodily injuries or sicknesses comparable in severity and nature to the bodily injuries or sicknesses treated or being treated. Allowable Charge will not exceed the actual charge and means the usual, customary and reasonable amount determined by the Board of Trustees to be payable for a Covered Expense.

The term "area," as it would apply to any particular item for which an Allowable Charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of entities furnishing such items.

A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained.

2. The term "**Collective Bargaining Agreement**" includes:
 - (a) any collective bargaining agreements between the Unions and any employer which provides for the making of employer contributions to this Fund.
 - (b) Any extensions, amendments, modifications or renewal of any of the above described agreements, or any substitute or successor agreements to them which provide for the making of employer contributions to this Fund.
3. **Contributing Employer:** Any employer, including individual, partnership, corporation, firm, or other entity, which has entered into a Collective Bargaining Agreement with the Union, providing for contributions into the Fund, or such other employer as the Trustees may approve from time to time, if allowed by the Agreement of Trust establishing this Fund.
4. **Contribution:** The payment made or to be made to the Fund by any Contributing Employer under the provisions of a Collective Bargaining Agreement or subscriber agreement.
5. **Contribution For Dependent Coverage:** Your employer's Collective Bargaining Agreement and any policy established by the Board of Trustees may require that you or your employer make contributions if you elect dependent coverage.
6. **Covered Expense:** Those charges which are eligible for benefit payment according to the Major Medical Plan, which are determined by the Major Medical Plan to be medically necessary for the treatment of an injury or sickness and are not expressly excluded by the Major Medical Plan.
7. **Custodial Care:** Custodial care, or domiciliary care or care in an institution, primarily a place of rest for the aged, nursing home or any like institution. As further consideration for the Board of Trustees, the term, "Custodial Care" shall have the same meaning as contained in the federal Dependents' Medical Care Act, commonly known as "CHAMPUS," and regulations implementing the Act and the definition of custodial care contained therein.
8. **Deductible:** The amount you pay before the Plan pays benefits. Charges not considered Covered Expense may not be used to satisfy the deductible.

9. **Dependent:** The term "Dependent" means the Employee's lawful spouse and (a) unmarried natural children less than 19 years of age; (b) unmarried step-child, child under legal guardianship (proof of legal guardianship is required), legally adopted child, foster child, or child placed for adoption, less than 19 years of age provided such child is dependent upon the Employee for support and maintenance; (c) unmarried natural child, step-child, legally adopted child or foster child over the age of 19 but less than 25 years of age who is dependent upon the Employee for support and maintenance and a full-time student in an accredited institution of learning. Verification of student status by submitting a Student Certificate from the school registrar each semester is required for continued coverage under the Plan. The terms "legally adopted child" and "foster child" shall mean and include any minor who otherwise meets the age requirements here-in-before specified who is a legally adopted child or foster child-dependent by virtue of a Court Order specifying that the Employee has legal responsibility for custody and maintenance of the child, provided, the child primarily resides with the Employee in a regular parent-child relationship. The term "child placed for adoption" means a child less than 18 years of age for whom the Employee has assumed and continues to retain a legal obligation for total or partial support in anticipation of adoption of such child. When enrolling a Dependent, a copy of the marriage certificate, birth certificate, or Court Order may be requested.

Dependent shall include an unmarried child of the Employee who, upon attainment of the age limit specified above, is incapable of self-sustaining employment by reason of mental or physical handicap (provided the condition of the child existed before attainment of the age limit and while eligible hereunder) and who is solely dependent upon the Employee for support. The Board of Trustees may subsequently require proof of continuing incapacity. This extension of coverage under the Plan will continue until the earliest of: (1) the date he or she ceases to be eligible for reasons other than age, (2) the date he or she ceases to be incapacitated, or (3) the 31st day after the Trustees request, in writing, additional proof of incapacity and such proof is not furnished within the period of time, or any extension thereof granted by the Trustees.

A Dependent shall also include an Employee's child who is the subject of a Qualified Medical Child Support Order.

No other dependents will be covered under the Plan even though you may be morally or financially responsible for them.

A spouse or child in the full-time military, naval or air service will not be considered an eligible dependent.

THE TERM DEPENDENT WILL NOT INCLUDE ANY PERSON WHO IS THE SPOUSE OF AN ELIGIBLE EMPLOYEE AND WHO (1) HAS COVERAGE AS A RETIREE UNDER AN EMPLOYER SPONSORED PLAN OF GROUP COVERAGE AND (2) IS ELIGIBLE FOR FEDERAL MEDICARE COVERAGE.

10. **Doctor (Physician):** A Doctor of Medicine or Doctor of Osteopathy. To the extent that benefits are provided and while practicing within the scope of his/her license, doctor will also include physician assistant, assistant surgeon, anesthesiologist, dentist, podiatrist, chiropractor, acupuncturist, optometrist, ophthalmologist, or psychologist. Doctor will not include you or your dependents or any person who is the spouse, parent, child, brother or sister of you or your dependent.
11. **Drugs:** The term "Drugs" means any article which can be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Doctor or Dentist licensed by law to administer it.

12. **Emergency:** A sudden onset of a medical condition which in the absence of immediate medical attention could reasonably place the Participant's health in jeopardy, cause serious medical consequences, cause serious impairment to bodily functions, or cause serious and permanent dysfunctions of any bodily organ or part.
13. **Employee:** An individual within a unit covered by a Collective Bargaining Agreement providing for contributions to the Office and Professional Employees Locals 30 & 537 Health and Welfare Fund.
14. **Expenses Incurred:** The term "expenses incurred" means only the usual, customary and reasonable fees and prices regularly and customarily charged for the medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Any agreement as to fees or charges made between you and a Doctor or Hospital will not bind the Trust in determining its liability with respect to expenses incurred. Expense incurred is determined to be incurred on the date on which the service or supply which gives rise to the expense or charge is rendered or obtained.
15. **Extended Care Facility:** The term "Extended Care Facility" means an institution which is primarily engaged in providing in-patients with (1) skilled nursing care and related services for patients who require medical or nursing care, or (2) rehabilitative services for the rehabilitation of injured, disabled or sick persons, and which meets all of the following requirements:
 - (a) it is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours a day supervision of a Doctor or a Registered Nurse;
 - (b) it has available at all times the services of a Doctor who is a staff member of a Hospital;
 - (c) it has on duty 24 hours a day a Registered Nurse, licensed vocational nurse (L.V.N.), or skilled practical nurse, and it has a Registered Nurse on duty at least eight hours per day;
 - (d) it maintains a clinical record for each patient;
 - (e) it is not, other than incidentally, a place for rest, a place for drug addicts, a place for alcoholics, a hotel or a similar institution;
 - (f) it complies with all licensing and other legal requirements, and is recognized as an "Extended Care Facility" by the Secretary of Health and Human Services of the United States pursuant to Title XVII of the Social Security Amendments Act of 1965, as amended.
16. **Fund:** The Office and Professional Employees Locals 30 & 537 Health and Welfare Fund.
17. **Home Health Care Agency:** The term "Home Health Care Agency" means an organization or agency which meets the requirements for participation as a "home health care agency" under Medicare.
18. **Hospice:** A hospice or public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.
19. **Hospital:** A "legally constituted hospital" means an institution which meets all of the following requirements:

- (a) It is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff or duly qualified physicians.
 - (b) It continuously provides 24 hours a day nursing service by or under the supervision of registered graduate nurses and is operated continuously with organized facilities for operative surgery; and
 - (c) It is not, other than incidentally, a place of rest, a place for the aged, a place for the treatment of drug addiction or alcoholism, a place for the mentally ill or emotionally disturbed, or a nursing home.
 - (d) A psychiatric hospital as defined by Medicare which is qualified to participate in and is eligible to receive payment under and in accordance with the provisions of Medicare relative to psychiatric inpatient care.
- 20. **Major Medical Plan:** As described herein whereby you are free to choose your own physician and your own hospital, to avail yourself of any service provided under the program. Allowance for hospital expenses, as well as surgical procedures, are limited as indicated herein.
- 21. **"Medically Necessary"** means that, at the sole and absolute discretion of the Board of Trustees, each service or supply meets all of the tests listed below:
 - (a) it is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects, and birth defects;
 - (b) it is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards;
 - (c) it is not mainly for the convenience of the Participant or of the Participant's Doctor or other provider; and
 - (d) 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 Participant's needs to be confined as an inpatient are due to the nature of the services rendered or due to the Participant's condition and that the Participant cannot receive safe and adequate care through outpatient treatment.
- 22. **Medicare:** The term "Medicare" as used herein, means the program established under Title XVII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may thereafter be amended.
- 23. **Open Enrollment:** The month of January of each year. This is the period of time in which you may elect to change from either the Major Medical Plan or Kaiser Foundation Health Plan and the Basic Dental Plan or the United Concordia Pre-Paid Dental Plan. **If you have not previously covered your dependents, you may do so during the open enrollment period.** Enrollment Cards must be received by the Trust Fund Office no later than January 31st of each year in order for your coverage to be changed effective February 1st. See pages 30 and 31.
- 24. **Participant:** An eligible Employee or eligible Dependent.

25. **Pre-Paid Plan:** Any plan entered into by contract between the Fund and any outside organization to provide pre-paid benefits to the participants of this Trust Fund in lieu of those benefits provided under the Major Medical Plan, or Basic Dental Plan.
26. **Registered Nurse:** The term "Registered Nurse" means a registered graduate nurse.
27. **Totally Disabled:** If your eligibility is based on active employment, you will be considered totally disabled while, as a result of bodily injury or sickness, you are prevented continuously from engaging in any occupation for which you are qualified by reasons of education, training or experience.
- A person whose eligibility is not based on active employment will be considered totally disabled while, as a result of bodily injury or sickness, he or she is unable to engage in his or her regular and customary activities and is not engaged in any occupation for wages or profit.
28. **Union:** The term "Union" means Office and Professional Employees International Union Local 30 and Office and Professional Employees International Union Local 537.

ELIGIBILITY RULES

The following only applies if eligibility provisions are not addressed in a collective bargaining agreement approved by the Board of Trustees:

EMPLOYEE

Who is Eligible

Any full-time, regular part-time or temporary employee for whom a full monthly contribution (as determined by the Board of Trustees) has been paid by one or more participating employers.

When an Employee Becomes Eligible

Hours worked in one month (February, for example) are paid by contributions in the following month (March) and provide eligibility for the following month (April). Full monthly contributions as determined by the Trustees must be made to initiate and maintain eligibility for medical and dental benefit coverage.

Reinstatement

If an employee is terminated and returns to active employment, he/she will become eligible as provided for above.

Effective Date of Coverage

Employees will become covered on the date they become eligible.

Termination of Coverage

Coverage for a participant will automatically terminate on the earliest of the following dates:

1. On the date the expiration of the period for which the last required contribution was made.
2. Subject to the section on Continuation of Coverage During Military Service, upon the date of entry into full-time military service.
3. On the day the employee becomes covered under another health and welfare program.
4. The date the Board of Trustees terminates the benefits provided by the Fund.

DEPENDENT

Medical and Dental coverage for eligible dependents* is optional and is available at a monthly cost to you. If you wish to enroll your dependents, be sure to list them on the enrollment card(s) and notify your Employer immediately to ensure that the appropriate payroll deductions are made and remitted accordingly to avoid any additional retro-payments on your part.

* See definition of *Dependent* on page 12.

Who is Eligible

If an employee wishes to enroll dependents as defined herein, they must be enrolled at the same time as the Employee. Thereafter, any person who becomes a dependent, such as a new spouse or newborn child, may be enrolled by the employee submitting an updated enrollment form within 30 days from the date of marriage or birth.

Dependents not previously enrolled may ONLY be enrolled as dependents during the OPEN ENROLLMENT PERIOD by submitting an enrollment application. See pages 30 and 31 for additional details regarding general enrollment information, Open Enrollment and Special Enrollment Rights.

Enrollment

To obtain dependent coverage or update dependent coverage, an enrollment card must be completed and filed with the Trust Fund Office within 30 days.

Effective Date of Coverage

Dependents will become covered (subject to "Enrollment" above) as follows:

1. If written application is made within 30 days after the Employee becomes eligible, dependent coverage shall take effect on the first day of the month following the month for which a dependent contribution is received.
2. Coverage for a newly eligible dependent shall become effective on the first day of the month following receipt of the enrollment card (received within 30 days from the date that the dependent was acquired) and providing any necessary payment for dependent coverage has also been made.
3. The date following release from active duty in the military (provided the required dependent contribution is made).

Termination of Coverage

The coverage of the dependent shall terminate on the earliest of: (1) the date the dependent ceases to be a dependent as defined herein; (2) the date the Employee's eligibility terminates; (3) the date the dependent premium is due and not paid to the Trust Fund; or (4) subject to the section on Continuation of Coverage During Military Service, the date the dependent enters into full-time active duty with the Armed Services.

Qualified Medical Child Support Orders (QMCSO)

Federal law requires the Plan, under certain circumstances, to provide coverage for your children when you and your spouse divorce. The process begins when the plan receives a Qualified Medical Child Support Order (QMCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

1. Issues from a court of competent jurisdiction pursuant to a state's domestic relations law:

2. Requires you to provide only the group health coverage available under the plan for your children, even though you no longer have custody; and
3. Clearly specifies:
 - a. Your name and last known mailing address and the names and addresses of each child covered by the order;
 - b. A reasonable description of the coverage to be provided;
 - c. The length of time the order applies; and
 - d. Each plan affected by the order.

If the Plan receives an order and it is determined to be qualified, the child will be enrolled on the date of the determination or the date the necessary payment for dependent coverage is received, whichever is later. You must be a participant under the Plan before any dependent may be covered by the Plan. The child's custodial parent, legal guardian, or a state agency can make application for coverage, even if you do not. If you have any questions on any of these requirements, please contact the Trust Fund Office.

CONTINUATION OF COVERAGE

EMPLOYER PAID COVERAGE

Disability

If an Employee is on Worker's Compensation or California State Disability, the employer, if specified in its Collective Bargaining Agreement, may make a full monthly contribution at the current contribution rate to maintain coverage for that Employee, for a period up to but not exceeding SIX months. Proof of disability may be required by the Fund Office.

RETIREE PAID COVERAGE

Self-Pay Retirees

If you are an active Employee covered under the Fund, you will be eligible for Self-Pay Retiree coverage if you:

1. Have been under continuous covered employment for a ten year period immediately preceding retirement, and
2. Retire between the ages of 55 and 64 inclusive, and
3. Continue to pay timely, your contribution rate until you reach age 65 or become eligible for MEDICARE, at which time eligibility under this Plan will cease. The contribution rate for Self-Pay Retirees is the same as COBRA rates.

CONTINUATION OF COVERAGE DURING MILITARY SERVICE

Right to Continuation Coverage

An eligible Employee, Dependent, COBRA Participant or QMCSO Beneficiary ("Eligible Individual") may continue as an Eligible Individual without interruption if such status would otherwise terminate as a result of an Employee's absence from employment by reason of service in the Armed Forces of the United States, provided the Eligible Individual satisfies the application and premium payment requirements of this section.

Application and Payment of Continuation Coverage

In order to qualify for continuation coverage, the Eligible Individual must apply for continuation coverage by properly completing an election form provided by the Trust Fund Office within 60 days of entering the Armed Forces full-time.

Such Eligible Individuals that elect continuation coverage must pay premiums in the same amount (not to exceed 102 percent of the full premium under the Plan), form and manner as provided for COBRA Participants in this section on "COBRA" Self-Payment. Notwithstanding the above, in the event an Employee performs less than 31 days of service in the Armed Forces, such person shall not pay more than the employee share, if any, of such coverage.

Any liability under the Plan for employer contributions and benefits arising under this section shall be allocated to:

1. the last contributing Employer employing the Eligible Individual before such individual served in the Armed Forces; or
2. If such contributing Employer is no longer functional, to the Plan.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage under this section shall be the lesser of:

1. the 18-month period beginning on the date on which the Eligible Individual's absence begins; or
2. the period ending on the day after the date on which the Eligible Individual fails to apply for or return to a position of employment with a contributing Employer, as determined under Section 4312(e) of the Uniformed Services Employment and Reemployment Act of 1994.

"COBRA" SELF-PAYMENT

COBRA CONTINUATION COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you and/or your dependents lose coverage under the Plan, you and/or your covered dependents might be eligible to continue your medical, prescription drug, dental and vision coverage by self-payment for a temporary period. You will be allowed to continue only the coverage that you had as an active employee. To be eligible, a qualifying event causing the loss of coverage must take place.

Qualifying Events for Employees and Dependents

A qualifying event occurs:

1. if your employment ends (for reasons other than your gross misconduct); or
2. if your hours are reduced to the point where you would not ordinarily be covered by the Plan.

In this case, you and/or your dependents may continue the coverage you had for up to 18 months following the month in which your termination or reduction in hours occurs. COBRA Continuation Coverage requires payment of 102% of the cost to the plan for similarly situated individuals who have not incurred a qualifying event. COBRA premiums are routinely adjusted effective each February 1.

If, at any time during the first 60 days of COBRA coverage, you or a covered dependent are determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, coverage may be continued for an additional 11 months, for a total of 29 months. Coverage may be continued for all family members. The Trust Fund Office must be informed within 60 days of the Social Security determination of disability and before the end of the 18 month continuation coverage period. The cost for the additional 11 months is 150% of the plan's total cost of coverage. In the event you are no longer considered disabled by Social Security, you must notify the Trust Fund Office within 30 days of the date of the Social Security Administration's determination. Your coverage will stop the first day of the month that begins more than 30 days after the re-determination.

Qualifying Events for Dependents

If one of the following qualifying event occurs, your spouse's and/or your children's coverage may be continued for up to 36 months:

1. You die while you and your dependents are covered by the plan.
2. Your divorce or legal separation.
3. You become entitled to Medicare.
4. Your child ceases to be a dependent as defined by the Plan.

If while on continuation coverage due to your termination or reduction in hours, your spouse and/or dependents have another qualifying event; for example, assume that you, your spouse and children continued coverage for 18 months because of your termination of employment; if you died during this 18-month period, your spouse and children may continue coverage for a total of 36 months from the date of termination of employment.

Also, a qualifying event is a proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.

Type of Coverage

An Eligible Individual may continue his/her "core coverage" only, or both "core plus non-core coverage."

The term "core coverage" as used herein means all Plan benefits provided to similarly situated Eligible Individuals for whom a Qualifying Event has not occurred, except life insurance, accidental death and dismemberment benefits, dental benefits and, for those not enrolled in Kaiser, vision care benefits.

The term "core plus non-core coverage" as used herein means, for those not enrolled in Kaiser, the Plan's "core coverage," dental benefits and vision care benefits provided to similarly situated Eligible Individuals for whom a Qualifying Event has not occurred. For those enrolled in Kaiser, the term "core plus non-core coverage" means the Plan's "core coverage" and dental benefits provided to similarly situated Eligible Individuals for whom a Qualifying Event has not occurred.

If "core plus non-core coverage" is not elected at the time an election is made for initial continuation coverage, it cannot be elected at a later date. You may, however, change your medical from Kaiser to Major Medical Plan or vice versa and from the prepaid dental plan to the Basic Dental Plan or vice versa at Open Enrollment.

Nothing in this section shall be interpreted to give an Eligible Individual the right, at the time continuation coverage is elected, to change his/her coverage option (i.e., Major Medical Plan, Kaiser) from those in effect for him/her on the day preceding the day coverage would otherwise terminate as a result of the qualifying event.

Withdrawal of Contributing Employer

COBRA continuation coverage will not be offered to you or your dependents if you lose eligibility because your employer withdraws from or is no longer contributing to the Plan.

However, if you or your dependents are covered under COBRA continuation coverage when your former employer stops contributing to this Fund, you may continue your coverage under COBRA until the end of your continuation period (i.e., 18 months, 36 months). But if your former employer has an existing plan or establishes a new plan to cover a class of active employees formerly covered under this Fund, your COBRA continuation coverage will be terminated under this Plan since your former employer is required to provide COBRA continuation coverage for you and/or your dependents.

Notice Requirement

If your spouse or child qualifies for continuation of coverage due to a qualifying event such as divorce, legal separation, or ceasing to meet the definition of a dependent under the plan, you must notify the Trust Fund Office. This notice should be given before the qualifying event, or as soon as possible thereafter, but not more than 60 days after the qualifying event.

If this notice is not provided to the Trust Fund Office within 60 days, your dependent's right to continue under COBRA will be lost.

In the case of any other Qualifying Event, the Employer will notify the Trust Fund Office.

Once the Trust Fund Office is notified of a Qualifying Event, an election notice will be sent to the Employee and Qualified Beneficiaries explaining their options to continue coverage. This will be addressed to the Employee and dependents at the address of record maintained by the Trust Fund Office. It is the responsibility of all Qualified Beneficiaries to keep the Trust Fund Office informed of their current mailing address.

If you are a covered former employee, you may add your newborn or adopted children to your continuation coverage, provided you add the child(ren) within 30 days of the birth or adoption and pay the additional premium, if any. These children whom you add to coverage will be considered Qualified Beneficiaries under the law.

Election Requirement

You and/or your dependents must make written election on the forms provided within 60 days after the later of:

1. The date coverage would end if no continuation was elected; or
2. The date the COBRA election notice is provided.

The election form must be received by the Trust Fund Office within the stated 60-day period; otherwise, the continuation option expires. Any Qualified Beneficiary who fails to send the election form to the Trust Fund Office to continue coverage within the 60-day period **will not** be permitted to continue any level of coverage.

Premium Payment

Your initial premium payment must be paid to the Trust Fund Office within 45 days of the date you elected COBRA. Your payment must cover the period of coverage from the date you elected COBRA to the date of the loss of coverage due to the qualifying event. To ensure continuous coverage, you should enclose your first payment with your election.

Subsequent payments must be received at the Trust Fund Office by the first day of the month preceding each coverage month. The following is a monthly remittance schedule for COBRA contributions:

<u>Coverage Month</u>	<u>Payment Due</u>
February	January 10 th
March	February 10 th
April	March 10 th
May	April 10 th
June	May 10 th
July	June 10 th
August	July 10 th
September	August 10 th
October	September 10 th
November	October 10 th
December	November 10 th
January	December 10 th

If you fail to respond or make the required self-payments according to the schedule outlined above, your coverage will terminate after a grace period of 30 days without further notice and you will not be permitted to make retroactive payment or payment of any month following the termination of your eligibility. You are responsible for making your monthly COBRA payments by the due date. No bills or reminders will be sent.

To ensure that you receive proper credit for any self-payment made, please include your Social Security Number on your check or cover note and indicate the coverage month for which you are making payment.

Automatic Coverage for Dependents of Covered Employees Choosing Continuation Coverage

When the covered Employee chooses to continue coverage, coverage for his or her spouse and dependents will continue automatically unless the spouse *independently* declines coverage. But, if the covered Employee chooses not to continue coverage, his/her spouse and eligible dependents may still choose coverage. Of course, in all circumstances anyone electing continued coverage must pay for it.

Transfer Rights

If you are covered by a regional plan (like an HMO that covers a limited geographic area), and you relocate to another area where your employer has an active workforce, you are entitled to elect the coverage available to an active employee working in that area. Of course, under no circumstances would such a transfer prolong your 18, 29 or 36 months of COBRA coverage.

Termination of Continued Coverage

The continued coverage will end **automatically** as of the date any of the following situations occur:

1. The date the Plan ends.
2. The date your employer, through which COBRA was elected, is no longer a Contributing Employer and has an existing plan or established a new plan to cover a class of active employees formerly covered under this Plan.
3. The required premiums are not paid on a timely basis. To be paid on a timely basis, the premium must be paid within 30 days of its due date (or within 45 days of the due date for the initial premium payment).
4. The date you become, after the date of election, entitled to Medicare or covered under any other group health plan, which does not contain any exclusion or limitation with respect to any preexisting condition.
5. The first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.
6. The date the maximum period of continued coverage has been provided, i.e., 18 or 36 months, or in the case of a disability extension, 29 months.

QUESTIONS

If you have questions about your COBRA Continuation Coverage, you should contact the Trust Fund Office at:

O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746
Phone: (562) 463-5065 or
(800) 386-4350

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

California COBRA Extension - Medical Benefits (for Kaiser Participants Only)

If you are a COBRA qualified beneficiary with Kaiser on or after January 1, 2003 California law requires HMOs and insurance carriers such as Kaiser to extend your medical continuation coverage up to 36 months (combined federal and state COBRA extensions). California COBRA Extension does not apply to vision or dental coverage. The California COBRA extension will only apply to you if you have an 18-month or 29-month COBRA qualifying event.

In order to be eligible for the California COBRA extension, you must have exhausted your federal COBRA coverage and you must be enrolled in Kaiser on the date your federal COBRA coverage ends.

Your premium may increase to 110% of the cost of coverage and must be paid directly to Kaiser. You must apply for this COBRA extension before the end of your federal COBRA Continuation Coverage. Call the Trust Fund Office or Kaiser for more information.

Conversion Privilege for Kaiser Participants

At the end of the 18, 29 or 36 months of continuation-of-coverage period, you may be entitled to enroll in an individual conversion plan provided by Kaiser, if you were a Kaiser member under COBRA. This coverage may cost more and/or provide fewer benefits than your Group Health coverage. You must apply for this conversion coverage within 31 days after your continued coverage ends. Call Kaiser for more information or if you wish to enroll for this conversion plan.

**EXTENSION OF MEDICAL
COVERAGE DURING TOTAL DISABILITY**

If you or your covered dependents become Totally Disabled before your eligibility terminates, and do not choose to continue coverage under COBRA, benefits under the Major Medical Plan FOR ONLY THAT SPECIFIC DISABILITY will continue until the earliest of the following dates:

1. the date of recovery from that disability; or
2. the date of eligibility for benefits under any other Group Plan which has no limitations as to the disabling condition; or
3. a maximum of 12 months following the termination of eligibility.

Total Disability must be confirmed in writing by the attending physician.

FAMILY MEDICAL LEAVE ACT

The Family Medical Leave Act enacted by Congress in 1993 provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the employees. The federal legislation specifically provides that more liberal provisions of state law are permitted and also provides that more liberal provisions within collective bargaining agreements are permitted.

It is not the role of the Trustees or Fund to determine whether or not an individual employee is entitled to leave with continuing medical care under the federal statute, any state statute or the provisions of a collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee and where applicable, the local union.

To the extent that participants are entitled to leave with continuing medical coverage pursuant to the federal act, state legislation or provisions contained within a collective bargaining agreement, the Fund will provide continuing medical coverage so long as required monthly contributions are received from the contributing employer. Rights under this section in no fashion affect rights under COBRA or rights to continuing medical care pursuant to the disability extension features contained within the Major Medical Plan.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, 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 is reduced by your prior health coverage. 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 group health plan, a certificate of prior coverage may help you obtain coverage without a preexisting condition exclusion.

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

A certificate of coverage will automatically be sent to you and your covered dependents at your last known address if your coverage ends. If you elect COBRA continuation coverage, you will also receive a certificate of coverage after COBRA coverage ends. You and your covered dependents may also request a certificate of coverage within 24 months of losing coverage.

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

The Board of Trustees of the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund ("Fund") adopted the following in order to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations known as the Privacy Rule promulgated by the U.S. Department of Health and Human Services. The Privacy Rule is set forth at 45 CFR parts 160 and 164, subparts A and E.

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA

The Fund will use and disclose protected health information (“PHI”) in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

PHI is defined as individually identifiable health information that is maintained or transmitted by the Fund in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, employer, health care clearinghouse or this Fund and relates to the past, present or future physical or mental health condition of you or your eligible dependents, including payment information for the provision of health care. When held by this Fund, it also means information that either identifies you or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number or choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee, retiree, or Medicare enrollee.

THE FOLLOWING USES AND DISCLOSURES OF PHI, AND CORRESPONDING RIGHTS AND DUTIES, APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS

PERMITTED USES AND DISCLOSURES OF PHI

The Fund and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefit claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

REQUIRED USES AND DISCLOSURES OF PHI

The Fund must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of the U.S. Department of Health and Human Services (“HHS”) and its Office of Civil Rights (“OCR”) or other authorized government organizations to investigate or determine the Fund’s compliance with the Privacy Rule.

AGREED TO USES AND DISCLOSURES OF PHI BY YOU AFTER AN OPPORTUNITY TO AGREE OR DISAGREE TO THE USE OR DISCLOSURE

The Fund will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected.

ALLOWED USES AND DISCLOSURES OF PHI FOR WHICH AUTHORIZATION OR OPPORTUNITY TO OBJECT IS NOT REQUIRED

The Fund will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities. These uses and disclosures are more fully described in the Fund's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Administrative Office.

YOUR INDIVIDUAL RIGHTS

HIPAA and the Privacy Rule afford you the following rights:

1. You (or your personal representative) have the right to request restrictions on how the Fund will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, the Fund is not required to agree to such a request. If the Fund agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You (or your personal representative) will be required to complete a form requesting any restriction.
2. You (or your personal representative) have the right to request to receive communications of PHI from the Fund either by alternative means or at alternative locations. The Fund may agree to accommodate any such request if it is reasonable. The Fund, however, must accommodate such requests if you clearly state that the disclosure of all or a part of the PHI could endanger you.
3. You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as the Fund maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for the Fund, or other information used in whole or in part by or for the Fund to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. The Fund may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you have the denial

reviewed, if applicable, and a description of how you may file a complaint with the Fund or the HHS or its OCR.

4. You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. The Fund has 60 days after the request is made to act on the request. A single 30 day extension is allowed if the Fund is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of his or her PHI.
5. You (or your personal representative) have the right to request an accounting of disclosures of PHI by the Fund. The Fund will provide such an accounting only for a six-year period starting from the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, the Fund is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures by the Fund. The Fund will provide an accounting of disclosures within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will be provided. If more than one request for an accounting is made within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

ACCESS BY PERSONAL REPRESENTATIVES TO PHI

The Fund will treat your personal representatives as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with a limited health care power of attorney regarding a specific treatment, such as use of artificial life support, is the representative only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

The Fund retains discretion to deny a personal representative access to PHI if the Fund reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect to a minor child's health care information.

THE FUND'S DUTIES

In accordance with the Privacy rule, only certain employees may be given access to your PHI. The Administrative Office has designated this group of employees to include Claims Adjusters, Claims File Clerks, Mail Clerks, Eligibility Certifiers, Supervisors and Managers. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

The Fund is required by law to provide you with its Notice of Privacy Practices ("Notice") by April 14, 2003 and thereafter, upon request. Also, the notice must be distributed by the Fund to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. The Fund is required to comply with the terms of the Notice as currently written. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to the date of the change. The Fund will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

The Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purposes of the use, disclosure or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to requests by a health care provider for treatment purposes, disclosures made to you, uses or disclosures pursuant to your authorization, disclosures made to HHS or its OCR for enforcement purposes, uses or disclosures that are required by law, and uses or disclosures that are required for the Fund's compliance with HIPAA's Administration Simplification Rules.

MISCELLANEOUS

The Fund may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you, such as your name and Social Security Number.

The Fund may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI that includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

The Fund will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages its use or purchase. However, the Fund may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the Plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

THE BOARD OF TRUSTEES' DUTIES

The Fund will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended the Fund's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the Plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in the Fund's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administrative Office.

COMPLAINTS

If you wish to file a complaint with the Fund or have any questions regarding the uses or disclosures of your PHI (i.e. access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address:

Dave Chapman, Privacy Officer
Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746-3434

A complaint may also be filed with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. The Fund will not retaliate against you for filing a complaint.

GENERAL ENROLLMENT INFORMATION

Enrollment Information and Procedure

It is necessary for all Employees eligible under this Fund to file a completed enrollment card with the Administrative Office to ensure prompt payment of claims and eligibility.

How to Enroll in the Medical Plan

1. Complete the 3-part medical enrollment card and be sure to indicate the medical coverage you want (Major Medical or Kaiser).
2. If you select the Kaiser Plan, you must also complete the enrollment application found in your Kaiser packet. Your enrollment cannot be processed without this form.

How to Enroll in the Dental Plan

1. For the Basic Dental Plan, complete the blue and white Basic Dental Plan enrollment card.
2. For the United Concordia Pre-Paid Plan, complete the United Concordia enrollment form. Be sure to fill in the provider number of the dental center you have selected.

SUBMIT ALL COMPLETED ENROLLMENT CARDS AND/OR FORMS TO THE ADMINISTRATIVE OFFICE AS SOON AS POSSIBLE FOR IMMEDIATE PROCESSING.

REMEMBER - This is YOUR Health and Welfare Plan. In order to serve you most effectively, the Fund needs your assistance in these ways:

1. Be sure to file an enrollment card with the Trust Fund Office and KEEP IT UP TO DATE as to your dependents and address. Without up to date information, delays and unnecessary expenses may occur in the payment of claims.
2. Carry your medical identification card with you at all times. Be sure to show it to the admitting desk when entering a hospital, and to the doctor or nurse, on the FIRST office visit.

How to Enroll in Medicare

If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application form during the three month period prior to the month in which you become 65 years of age in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security Office 90 days prior to your 65th birthday and ask for an application card.

ANNUAL OPEN ENROLLMENT

Open Enrollment is offered to all participants once each year in the month of January. During that period, you may change your health coverage to either of the two Medical Plans or two Dental Plans available. Notice of the upcoming Open Enrollment is mailed to all participants in December to be filed in January. The change will then become effective February 1st and the Major Medical Plan restriction on pre-existing conditions outlined on page 38, item 15 is waived (Kaiser has no pre-existing condition provision).

Dependents not previously enrolled may also be added during Open Enrollment. Their coverage will become effective February 1st and the Major Medical restrictions regarding pre-existing conditions outlined on page 38, item 15 **will apply**.

The option of changing health coverage and/or adding dependents not previously enrolled is only available during Open Enrollment. If not elected at that time, you will not have another opportunity to make the change and/or dependent addition until the next Open Enrollment.

Special Enrollment Rights

Although the collective bargaining agreements (CBA) do not allow you to decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, the law requires that the Plan inform you of your special enrollment rights.

If you become eligible for coverage through a new employer who does not contribute to this Trust Fund but you decline coverage under that new plan because of other group health coverage, and you later lose that other group health you may in the future be able to enroll yourself or your dependents in your employer's group health coverage, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Call the Trust Fund Office if you would like more information about this right.

FUND OPERATION

The Fund Administrator is the Joint Board of Trustees

The Board of Trustees is as follows:

EMPLOYER TRUSTEES

James K. Bernsen
13191 Crossroads Pkwy No., Ste. 205
City of Industry, California 91746

Ronald T. Kennedy
13191 Crossroads Pkwy No., Ste. 205
City of Industry, California 91746

Leon F. Marzillier
13191 Crossroads Pkwy No., Ste. 205
City of Industry, California 91746

Michael T. Massey
Piping Industry Progress & Education
Fund
501 Shatto Place, Suite 200
Los Angeles, California 90020

Patrick McGinn
Southwest Carpenters Training Fund
533 So. Fremont Avenue, Suite 401
Los Angeles, California 90071

EMPLOYEE TRUSTEES

Jacqueline K. White-Brown
OPEIU Local #537
3229 East Foothill Blvd.
Pasadena, California 91107

Walter Allen, Jr.
OPEIU Local #30
4560 Alvarado Canyon Road, #2A
San Diego, California 92120

Tina Marie Littleton
OPEIU Local #537
3229 East Foothill Blvd.
Pasadena, California 91107

Michelle Ponce
OPEIU Local #537
3229 East Foothill Blvd.
Pasadena, California 91107

INFORMATION REQUIRED BY ERISA

The Employee Retirement Income Security Act of 1974 (ERISA), as amended, requires that certain information be furnished to each participant in an employee benefit plan, as follows:

Name of Plan

This Plan is known as the OPEIU Locals 30 & 537 Health and Welfare Trust Fund.

Plan Identification Number

The Plan Identification Number is 95-6047601. This Plan was established and is maintained as a result of collective bargaining between Employers and Local Unions as determined by the Trustees. A copy of any such agreement may be obtained upon written request to the Fund Office or can be examined at the Fund Office during normal business hours. Upon written request participants and beneficiaries may also obtain information as to whether a participating employer or union is a sponsor of the Plan and that employer's or union's address.

Type of Plan

This Plan can be described as a plan which provides health and welfare benefits for eligible employees and their dependents.

Type of Administration

This Plan is administered by the Joint Board of Trustees with the assistance of:

The Plan Administrator at the Fund Office:

OPEIU Locals 30 & 537 Trust Fund Office
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746

The Agent for Service of Legal Process

Mr. Patrick T. Connor of DeCarlo, Connor & Shanley has been designated by the Trustees as agent for the purpose of accepting legal process. His address is 533 South Fremont Avenue, 9th Floor, Los Angeles, California 90071-1706. Service of legal process may also be made on any member of the Board of Trustees.

The Fund is sponsored by a joint Labor-Management Board of ten (10) Trustees. Half the Board members represent the participating Union, which is the Office and Professional Employees International Union Locals No. 30 and No. 537, AFL-CIO, CLC, and half represent participating employers. The name, address and telephone number of the Board is:

Board of Trustees of the OPEIU Locals 30 & 537 Health and Welfare Fund
c/o Benefit Programs Administration
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746
(562) 463-5065

Sources of Plan Benefits

Hospital and medical benefits are paid by the Trust Fund unless you have enrolled in Kaiser. If you are enrolled in Kaiser, the Trust Fund pays a monthly premium to Kaiser on your behalf and Kaiser is financially responsible for your claims. Prescription drug benefits are administered by Express Scripts and paid by the Trust Fund. Dental benefits for the Basic Dental Plan are paid by the Trust Fund. If you are enrolled in United Concordia, the Trust Fund pays a monthly premium to United Concordia on your behalf and United Concordia is financially responsible for your claims. Vision care benefits are administered by Vision Service Plan and paid by the Trust Fund. Life insurance and Accidental Death and Dismemberment benefits are paid through an insurance policy between the Fund and Unimerica. Major Medical benefits are insured by American National Life Insurance Company for total covered claims paid by the Trust Fund exceeding \$125,000 in a Plan Year. "Financially responsible" mentioned above means net of participant deductibles and copays (if any).

Addresses for the providers mentioned above are as follows:

Kaiser Foundation Health Plan

393 East Walnut Street
Pasadena, California 91188

Express Scripts

14000 Riverport Drive
Maryland Heights, Missouri 63043

United Concordia

P.O. Box 10194
Van Nuys, California 91410-0194

Vision Service Plan

3333 Quality Drive
Rancho Cordova, California 95670

Unimerica (a UnitedHealth Company)

425 Market Street, 13th Floor
San Francisco, California 94105

American National Life Insurance Company

One Moody Plaza
Galveston, Texas 77550

Sources of Contributions to the Plan

The employer contributions and employee self-payments are received and held in trust by the Board of Trustees pending the payment of claims, premiums and administrative expenses.

Plan Year

This Fund is on a February 1st - January 31st fiscal year basis. For benefit purposes, the deductible accumulation period is on a calendar year basis (January 1 through December 31).

This booklet is a Summary Plan Description required by federal law. Every effort has been made in this summary to fully and accurately summarize your benefits and the rules and regulations of the Fund. A summary of the Annual Report of the Fund is furnished to you yearly by the Plan Administrator.

IMPORTANT

This Summary Plan Description is subject to the provisions of the Trust Agreement and cannot modify or affect the Trust Agreement in any way; nor shall you accrue any rights because of any statement in or omission from the Summary Plan Description.

MAJOR MEDICAL BENEFITS

COVERED EXPENSES

Are the usual, customary and reasonable medical charges which are subject to the EXCLUSIONS, LIMITATIONS, DEFINITIONS and all provisions of this Plan. Covered expenses are further defined as expenses incurred by an eligible Participant for the following which are approved by a Doctor and are reasonably necessary for the care and treatment of a covered sickness and/or injury.

1. Local, surface ambulance transportation to and from the nearest hospital where care and treatment of the illness and injury can be given.
2. The charges made by an anesthesiologist and/or anesthesiologist for the administration of anesthesia.
3. The charge for blood and blood plasma (if it is not replaced).
4. Diagnostic, laboratory, sonography, radium and radioisotope and x-ray expense.
5. The charges for the rental of a wheelchair, hospital bed; other durable mechanical equipment up to the purchase price of the item, subject to the approval of the Board of Trustees of this Fund.
6. The charges made by an extended care (skilled nursing) facility (limited to a 60-day maximum per disability) when such confinement:
 - (a) is preceded by confinement of at least three (3) days in a hospital;
 - (b) is for the same condition causing the preceding confinement;
 - (c) commences within 7 days after discharge from such confinement.
7. The charges made by a hospice for hospice care only if:
 - (a) the expense is incurred by a covered person diagnosed by a Doctor as terminally ill with a prognosis of 6 months or less to live; and
 - (b) the hospice provides a plan of care which:
 - (1) is prescribed by the Doctor
 - (2) is reviewed and approved by the Doctor monthly
 - (3) is not for any curative treatment; and
 - (4) states the belief of the Doctor and hospice that the hospice care will cost less in total than any comparable alternative to hospice care.

Hospice care includes services and supplies furnished by a Home Healthcare Agency as well as palliative and supportive medical nursing services.
8. The charges made by a licensed hospital, while the patient is a registered bed patient, for daily room and board, and limited to amounts shown in the Schedule of Benefits.
9. The charges made by a hospital for services and supplies.
10. Charges made by a licensed hospital or ambulatory surgery center for services and supplies furnished for outpatient care.

11. The charges made by a Registered Graduate and/or a Licensed Vocational Nurse for private duty nursing in a hospital or at home when need is certified by a physician. In a hospital, when the need is certified by the hospital administrator and/or the Head of the Nursing Service.
12. Oxygen and services/supplies for administration of oxygen.
13. The charges for professional services of a licensed Physical Therapist including acupuncture services. Maximum payable per calendar year, \$1,500.
14. The charges made by a Doctor for medical treatment. However, charges for services:
 - (a) by a **Podiatrist** are limited to 10 visits per calendar year with a maximum covered expense of \$75 per visit for all professional charges other than surgery and x-rays.
 - (b) by a **Psychiatrist** are limited to 1 treatment per day, inpatient or outpatient, 50 visits per calendar year. Group therapy is not covered.
 - (c) by a **Chiropractor** are limited to \$50 per visit. The maximum benefit payable for all chiropractic services, including x-rays is \$1,500 per calendar year.
 - (d) for allergy testing - skin testing and antigen extracts are covered up to a combined maximum payment of \$500 per calendar year. No other services related to allergy testing or treatment are covered.
 - (e) for treatment of morbid obesity are limited to one course of treatment per lifetime, up to a maximum payment of \$15,000. Refer to item 27 on page 40.
15. Pregnancy expenses of employee or spouse.
16. The charges for drugs, medicines and injections lawfully obtainable only upon the written prescription of a Physician. This includes contraceptive drugs and devices.
17. The charges for *initial* artificial limbs or eyes required to replace natural limbs or eyes while an eligible Participant is covered hereunder.
18. The charges incurred for a medical examination which results in a hearing device(s) being prescribed, will be reimbursed at 80% of the expenses incurred for the examination and hearing device(s) to a maximum of \$1,000 in a 3-year period. Benefits are not payable for battery replacements, or repair and maintenance, or for device(s) obtained more than 90 days after the examination prescribing the device.
19. Sterilization procedures (this is an exception to the requirement that a Covered Expense be for treatment of illness or injury).
20. The charges for casts, trusses, braces, crutches and surgical dressings.
21. Therapeutic and elective abortions of employee or spouse (the latter is also an exception to the requirement that a Covered Expense be for treatment of an illness or injury).
22. Charges for immunizations and inoculations. This includes all vaccinations and flu shots. Deductible does not apply to this benefit.
23. Charges up to \$150 for an annual health assessment that would include routine Pap smears and prostate exams. See page 40, item 39 for additional information on routine mammograms and pap smears. Deductible does not apply to this benefit.

24. Bone Density Testing for those:
- (a) Who are at least age 50, and
 - (b)
 - i. Who suffer from osteodystrophy or osteoporosis, or
 - ii. Estrogen deficient women at clinical risk for osteoporosis, or
 - iii. Members with vertebral abnormalities, or
 - iv. Members with hyperparathyroidism.

These tests must be ordered by a physician and must fall under procedure codes 76075, 76076 or 76078. These screening tests are covered at health care facilities only (not at health fairs or drugstores, as examples).

25. Mastectomies when medically necessary, and:
- (a) Reconstruction of the breast on which the mastectomy was performed;
 - (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (c) Prostheses and physical complications of all stages of mastectomy including lymphedemas.

LIMITATIONS AND EXCLUSIONS

No benefits of any kind shall be payable for expense incurred for:

1. Whole blood or plasma when such is donated or otherwise replaced.
2. Cosmetic surgery, or any complications resulting therefrom at any time in the future, unless necessitated by a non-occupational accidental bodily injury and then only for Covered Expenses incurred within one year from the date of the non-occupational accidental injury. This exclusion does not apply to treatment or surgery to alleviate a condition resulting from a congenital defect affecting bodily function.
3. Custodial care, or domiciliary care or care in an institution, primarily a place of rest, for the aged, nursing home or any like institution. As further consideration for the Board of Trustees, the term, "Custodial Care" shall have the same meaning as contained in the federal Dependents' Medical Care Act, commonly known as "CHAMPUS," and regulations implementing that Act and the definition of custodial care contained therein.
4. Dental Expenses - There shall be no benefit payment under these Medical Benefits in connection with any treatment on or to the natural teeth or for malocclusion except for the repair or alleviation of damage caused solely by accidental bodily injury and provided such treatment is rendered to the eligible Participant within one year after such accident.
5. Services, supplies and benefits for which an eligible Participant is entitled (or would have been entitled if proper application had been made) for any hospital, medical, dental or disability benefit paid by, reimbursed by or furnished by or payable under any Plan, authority or law of any Government or Government Agency Federal or State, Dominion or Province or any political subdivision thereof.
6. Benefits for which no charge is made or for which an eligible Participant is not required to pay, or is not billed nor would have been billed except for the fact that he/she has "insurance."

7. Charges in excess of the fees and prices generally charged in the community for services or supplies generally furnished with respect to the accidental bodily injury or sickness being treated. See definition of Allowable Charges.
8. Any service rendered to an eligible Participant by a spouse, child, brother, sister, parent or grandparent, or in-laws.
9. Eye refractions, glasses or contact lenses and related examinations including orthoptics or other visual training. Eye examinations for the purpose of prescribing corrective lenses, eye glasses or contact lenses, including the fitting thereof, except as provided under the separate Vision Care Program through Vision Service Plan.
10. Fetal Monitoring (including uterine monitoring) - charges for fetal monitoring and all attendant charges, which include, but are not limited to, the rental or purchase of the monitoring device, telephone fees for transmitting data, if any, professional fees for reading and interpreting the data, and any and all associated inpatient charges except for monitoring services performed at full term delivery.
11. Routine inpatient newborn care expenses are not covered, other than those necessary for the treatment of sickness or bodily injury of such infant. Circumcision is not a covered benefit.
12. Non-occupational accidental bodily injury or non-occupational sickness for which the person on whom claim is presented is not under the regular care of a Doctor, and for services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor based upon a prescription evaluation.
13. Any bodily injury, sickness or dental condition for which the person on whom claim is presented has or had a right to compensation under any Workers' Compensation, Occupational Disease Law or any other legislation of similar purpose, or any bodily injury or sickness which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain.
14. Personal comfort or beautification items.
15. Pre-existing conditions. Major Medical Plan Benefits will not be payable for expenses due to any injury or illness for which an individual has received medical care, treatment, advice, services or supplies prior to the effective date with respect to Employees and dependents. This exclusion shall cease to apply provided:
 - (a) The Employee or dependent goes 90 consecutive days ending on or after coverage under the Major Medical Plan commences without receiving medical care, treatment, advice, services or supplies in connection with the pre-existing condition; or
 - (b) The Employee or dependent is continuously covered under this Major Medical Plan for a period of six months.

The pre-existing condition limitation periods mentioned above may be partially or totally eliminated effective February 1, 1998. If you were enrolled in a Health Plan immediately preceding your eligibility into this Plan, you should submit the Certificate of Creditable Coverage issued to you by your prior Health Plan to the O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund Plan Administrator as soon as possible (keep a copy for your records). The information on the Certificate will determine the length of time the limitations above might be applicable.

The term "pre-existing condition" shall not include any condition for which benefits were available to Employees or dependents of Employees who were at one time eligible, laid off for no more than 6 months, and then return to an eligible status.

16. Transportation, except local professional ambulance service.
17. Treatment for alcoholism or drug addiction.
18. Psychiatric or psychological testing, evaluation and treatment, except as expressly provided in this Schedule of Benefits; hypnotherapy; group therapy, marriage and family counseling.
19. Biofeedback, hypnosis therapy, or pain clinics.
20. Routine examinations, preventive physical examinations, and orthopedic shoes (other than one pair per year). Premarital examinations and physical examinations for licensing, insurance, employment or school admission. However, the Plan does provide an annual health assessment benefit that includes routine Pap smears and prostate exams. This benefit has a \$150 maximum.
21. Any charges resulting from or directly related to any drug, device, medical or surgical procedure which is considered by the Fund to be experimental or investigative in nature. A drug, device, medical treatment or procedure is experimental or investigative:
 - (a) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
 - (b) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
 - (c) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
 - (d) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

22. Any injury inflicted by an eligible Participant to any other eligible Participant other than by accidental means; or any injury resulting from or occurring during the commission or attempt to commit an assault or felony; or any injury resulting from an eligible Participant being in an illegal occupation.
23. Services required due to insurrection, war (declared or undeclared), or any act of war and any complication therefrom.

24. Treatment by any method for jaw joint problems including temporomandibular joint syndrome (TMJ) and craniomandibular disorders, or other conditions of the jaw bone, skull, complex of muscles, nerves and other tissues related to that joint.
25. Charges incurred which are incidental to intersex (transsexual) operations or any resulting medical complications.
26. Hospitalization primarily for physical therapy or other rehabilitative care; hospitalization primarily for x-rays, laboratory or other diagnostic studies, except where such services cannot be rendered safely and adequately on an outpatient basis.
27. Treatment of obesity; any treatment for overweight problems resulting from overeating. In cases where a true endogenous or pathological glandular (endocrine) disturbance is established as the cause, benefits are limited to one course of treatment per lifetime with a maximum allowance of \$15,000, subject to review by the Fund's Medical Consultant. **All** treatment for obesity **must** be preauthorized in writing by the Trust Fund Office prior to the initiation of treatment. The Major Medical Plan will not provide benefits for any services that are not preauthorized. Treatment for morbid obesity (defined as a Body Mass Index of 40 or more) is also subject to review and preauthorization. Refer to item 14(e) on page 36.
28. Surgical procedures to attempt restoration of continuity of a previous vasectomy or vas ligation, or tubal ligation, transection or destruction for any reason.
29. Organ transplants except kidney transplant and hemodialysis treatment. Expenses incurred by an organ donor will not be considered a Covered Expense.
30. Charges incurred which are incidental to myopia surgery, radial keratotomy, or any other type of corrective surgery for myopia, except if necessary to prevent permanent and total loss of vision.
31. Stop smoking, nutritional and weight control programs.
32. Equipment in common use for other than medical purposes.
33. Vitamins, minerals, food supplements, digestive enzymes and substances, natural animal or vegetable substances, bacterial, viral substances or homeopathic preparations.
34. Occupational Therapy and Speech Therapy for any illness or injury.
35. Treatment of developmental disorders regardless of the cause including medical care, physiotherapy, occupational therapy, speech therapy, and educational services. This exclusion includes autistic disease of childhood, hyper kinetic syndromes, learning disabilities, behavioral problems, mental retardation, and hospitalization for environmental change.
36. Hospital expenses incurred for any dental procedure (covered or not covered) performed.
37. Pregnancy and abortion (therapeutic and elective) for dependents other than spouses.
38. Services and supplies associated with treatment for infertility/impotency. Sterilization reversal, artificial insemination or invitro fertilization.
39. Allowable Charges for routine mammograms will be covered no more than once per year for women age 40 to 75. Routine annual mammograms will also be covered for women younger than age 40 who have a mother or sister who has been diagnosed with breast cancer.

40. Allergy testing - skin testing and antigen extracts are covered up to a combined maximum payment of \$500 per calendar year. No other services related to allergy testing or treatment are covered.
41. Homeopathic or holistic treatment.
42. Fees for medical records or legal records.
43. Charges for breast implants, the removal of breast implants or any complication at any time resulting therefrom.
44. Penile implants unless required as a result of injury or an organic disorder.
45. Genetic testing to establish paternity of a child or tests to determine the sex of an unborn child.
46. Bone marrow transplants and high dose chemotherapy.
47. Air conditioners, humidifiers, or purifiers.
48. Claims not submitted within 12 months after expenses were incurred, except in absence of legal capacity. Additional information requested by the Trust Fund Office on behalf of the Board of Trustees that is not submitted in a timely manner may delay or deny payment.
49. Fees to complete claim forms.
50. Any other services not specifically covered by the Major Medical Plan.
51. Services or supplies rendered when, at the sole and absolute discretion of the Board of Trustees, are not considered to be medically necessary.
52. Charges for missed or broken appointments.
53. Any supplies or services: (1) for which no charge is made; or (2) for which the Participant is not required to pay in the absence of this Major Medical Plan; or (3) furnished by a hospital or facility owned or operated by the United States Government or any State Government or any authorized agencies thereof or furnished at the expense of such Governments or agencies except as required by federal law; or (4) which are provided without cost by any municipal, county or other political subdivision; or (5) court-ordered care.
54. Care or treatment in any penal institution or jail facility or jail-ward of any State or political subdivision.
55. Any care or treatment performed by a provider not specifically covered under the Major Medical Plan, regardless of whether or not the provider is licensed to perform such treatment, including, but not limited to, a marriage, family and child counselor or a licensed clinical social worker.
56. Charges for expenses incurred outside the United States unless when traveling and in need of urgent or emergency care.
57. Any surgical procedure or other treatment for complications of a procedure which is excluded under the Plan.
58. Outpatient prescription drugs and self-administered injectables (please refer to the Prescription Drug Benefits Section starting on page 46).

MAJOR MEDICAL PLAN COST CONTAINMENT PROGRAMS

A. PRE-ADMISSION AND CONCURRENT REVIEW PROGRAM

Administered by First Health.

Hospital Pre-Admission Notice and Hospital Services Concurrent Review are aspects of your Major Medical Plan which are designed to help you avoid unnecessary hospitalization and surgery, reduce hospital costs and protect your benefits.

The Major Medical Plan requires prior notice of all non-emergency hospitalizations. This can help you avoid the discomfort and expense of a hospitalization when an alternative is available. This approach also encourages your Doctor and the Hospital to let you go home, where it is comfortable and familiar, as soon as your health allows.

The Hospital Admissions Review Program is simple and convenient for you to use. **When hospitalization is discussed with you, inform your doctor of the Major Medical Plan's hospital pre-admission review notice. Your doctor must contact First Health at 1-800-528-7936 to initiate the review proceedings.** In the case of an emergency, a telephone call by the doctor or hospital within forty-eight (48) hours to First Health at the above number after you have been admitted is all that is required.

Your immediate notice to First Health of hospitalization will permit the maximum benefits for hospital services covered under the Major Medical Plan. On the other hand, if you enter the hospital without meeting the Major Medical Plan's notice requirements, or if First Health is not notified within forty-eight (48) hours of an emergency admission, you risk lower payment under the Major Medical Plan.

To help keep down the cost of hospital care, all admissions will be reviewed during your stay to determine whether continued hospitalization is medically necessary ("concurrent review").

Major Medical Plan Coverage 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 normal vaginal delivery, or less than 96 hours following a Caesarean Section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

IF YOU DO NOT OBTAIN PRE-ADMISSION REVIEW OR INITIATE CONCURRENT REVIEW, COVERAGE FOR ALL COVERED CHARGES INCURRED WILL BE REDUCED BY 30%.

EMERGENCY-ADMISSION REVIEW

Admissions that cannot be scheduled in advance, such as emergencies, are evaluated when you are admitted to be certain that the admission is medically necessary under the terms of the Major Medical Plan.

CLAIMS (RETROSPECTIVE REVIEW)

Claims for all admissions that are not certified as medically necessary will be reviewed to determine whether all or part of the stay will be covered. If you have additional questions, please call the Trust Fund Office at (562) 463-5065 or (800) 386-4350.

B. OUTPATIENT SURGICAL AND DIAGNOSTIC REVIEW PROGRAM

Administered by First Health.

The Outpatient Surgical and Diagnostic Review Program is designed to help you avoid unnecessary surgery, reduce costs and protect your benefits. You will, in turn, receive a free independent professional review.

When outpatient surgical procedures and diagnostic tests are discussed with you, inform your doctor of the Major Medical Plan's Outpatient Service Review Program. Your doctor must contact First Health at 1-800-528-7936 to have certain procedures or diagnostic tests pre-authorized.

IF YOU DO NOT RECEIVE AN OUTPATIENT SERVICE REVIEW WHEN REQUIRED AND BEFORE SERVICES ARE PROVIDED, YOUR BENEFITS UNDER THIS MAJOR MEDICAL PLAN WILL BE REDUCED BY 30%.

C. MEDICAL CASE MANAGEMENT PROGRAM

Administered by First Health.

Extensive, long-term treatment and/or potentially high-cost care may be subject to First Health's Medical Case Management Program. Case management assures that the Participant obtains quality medical care by the most cost-effective use of health care resources. Medical case management services seek alternative settings and providers, coordinate the sequence of care by facilitating communications among providers and patient, and perform continuous monitoring of care. First Health will notify your Doctor, if necessary, to initiate assistance under this program.

BENEFIT SUBSTITUTION POLICY

In some instances, a participant's medical needs may be best met by offering a service or supply which is not normally covered by the Major Medical Plan. When this is the case, the service or supply will be covered by the Major Medical Plan only if:

1. the service or supply is provided in lieu of a more costly service or supply which is covered by the Major Medical Plan; and
2. the benefit substitution is recommended by First Health and approved by the Board of Trustees.

BASIC DENTAL PLAN

This program is self-funded under the OPEIU Locals 30 & 537 Health and Welfare Trust Fund. The Trustees urge you and your dependents to use the Basic Dental Plan only when needed. This is your program, we therefore request your help and cooperation in curbing any abuse which might tend to have an adverse effect on the Fund.

Coverage Provided

The Basic Dental Plan has a \$50 annual deductible with a maximum amount payable per calendar year of \$2,000. Orthodontics has a separate \$2,000 maximum lifetime benefit. Benefits payable under the Plan depend on the services and supplies provided by the dentist. The schedule of coinsurance and the maximum fees payable are outlined in the Table of Allowances, which is provided automatically without cost to those enrolled under the Basic Dental Plan. If you do not receive yours automatically, please contact the Trust Fund Office for your free copy of the Table of Allowances.

Participation in Plan

Employees are entitled to participate in the Plan if they work under one of the Collective Bargaining Agreements that provides that their employer make contributions to the Fund on their behalf. There is no age or years of service requirement for participation. Also, certain non-bargaining unit employees are entitled to participate pursuant to special agreements between their employers and the Board of Trustees.

Source of Contributions

This Plan is funded through employer contributions, the amount of which is specified in the underlying Collective Bargaining Agreements. Also, self-payments by Employees are permitted if an Employee has qualified for dental coverage prior to discontinuation of employer contributions. A full monthly contribution at a rate determined by the Board of Trustees is required to maintain eligibility.

Pre-Certification

Pre-certification is required when services will exceed \$500 or when gold is to be used. Have your dentist call (562) 463-5065 or (800) 386-4350. Pre-certification is also required for prosthesis, and periodontal and root canal treatments. Certification will be valid for 90 days providing eligibility does not terminate during that period. Failure to obtain pre-certification may result in your not being covered for the treatment.

DENTAL LIMITATIONS AND EXCLUSIONS

This Basic Dental Plan does not pay expenses for:

1. More than one oral examination during any period of six consecutive months.
2. Dental procedures for cosmetic reasons, unless performed within two years after an accident to repair or alleviate damage from that accident which occurred while covered.
3. Temporary full prosthesis. The term "prosthesis" means any crown or any fixed or removable denture.
4. Replacement of an existing prosthesis which, in the opinion of the attending Doctor, is or can be made satisfactory.
5. Replacement of a prosthesis, except a crown necessary for restorative purposes only, for which benefits were paid under this Plan if the replacement occurs within five years from the date the expense was incurred, unless: (a) the replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth, or (b) the prosthesis is a stayplate or similar temporary partial prosthesis, and is being replaced by a permanent

prosthesis, or (c) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury.

6. Any procedures which began before the date the covered person became eligible under this Plan, or began after the individual ceased eligibility. Any supplies furnished in connection with such procedure, except that x-rays and prophylaxis treatment will not be considered as the beginning of a dental procedure.
7. Replacement of a lost or stolen appliance.
8. Dietary planning, oral hygiene instruction or training in preventive dental care.
9. Procedures which are necessary solely to increase vertical dimension, or restore the occlusion.
10. Adjustments or relining of a prosthesis within six months after the prosthesis is initially furnished.
11. Any treatment by any method for temporomandibular joint dysfunction (TMJ).
12. Any services rendered by a member of the immediate family of the person or of the person's spouse.
13. Any course of treatment which will cost over \$500 which is not preauthorized.
14. Any orthodontia treatment which is not pre-authorized.
15. Hospital expenses incurred for any dental procedure performed (covered or not covered).
16. Implantology.
17. Separate charges for Analgesia and/or Nitrous Oxide (except for general anesthesia given by a dentist for covered oral surgery procedures).
18. Any charge above allowable charges or for a procedure determined not to be necessary dental treatment as determined by the Board of Trustees.
19. Charges for completion of claim forms.
20. Charges for missed or broken appointments.
21. Claims not submitted within 12 months after expenses were incurred, except in absence of legal capacity. Additional information requested by the Trust Fund Office on behalf of the Board of Trustees that is not submitted in a timely manner may delay or deny payment.
22. Charges for expenses incurred outside the United States unless when traveling and in need of urgent or emergency care.
23. The replacement of a crown which was covered under this Plan, if such replacement occurs within five years from the date expense was incurred.
24. Effective with services incurred as of 1/1/04, the amount of benefits payable by this Plan and any other Plans will be coordinated so that the aggregate amount paid will not exceed the amount that would be paid if this Plan were the primary payer. The O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund payment will not exceed the amount which would have been paid if there were no other Plan involved.

PRESCRIPTION DRUG BENEFIT FOR MAJOR MEDICAL PLAN PARTICIPANTS

The Fund has contracted with Express Scripts to provide prescription drugs for eligible participants enrolled in the Major Medical Plan. A copayment of \$15 for generic and \$25 for a brand name prescription will be charged.

Prescription coverage is also available at non-Express Scripts pharmacies; payable at 60% of reasonable and customary charges after satisfaction of the \$600 major medical plan annual deductible for covered medical expenses.

A participant may obtain prescription drugs through Express Scripts in two ways. One is by using the Express Scripts prescription drug card. It is honored at over 55,000 pharmacies throughout the country (including the major chains). The other is Express Scripts' Mail Service prescription program which is set up to dispense up to a 90-day supply of maintenance medications which are generally needed for chronic medical conditions.

It is recommended that you use the Express Scripts drug card for your immediate prescription needs. It allows you to receive up to a 30-day supply of covered prescription drugs when they are dispensed by a participating Express Scripts pharmacy. When you need a prescription filled, just present your drug card along with the prescription and pay the applicable copayment as shown below:

Brand Name Prescriptions \$25
Generic Equivalent Drugs \$15

If you are currently using a maintenance medication, you can take advantage of Express Scripts' Mail Service. It allows you to receive, at your home, up to a 90-day supply of covered drugs for a single copayment as shown below:

Brand Name Prescriptions \$50
Generic Equivalent Drugs \$30

It is important for you to know that whenever an FDA "A-Rated" generic equivalent drug can be substituted for a brand name drug, you will be strongly encouraged to obtain the generic. Specifically, this means that if you choose to receive a brand drug when an A-Rated generic equivalent drug is available, you will be required to pay the difference in cost between the brand and the generic in addition to the applicable copayment. This will occur only if your doctor does not specifically prescribe a brand name drug.

Should you have any questions, please call the Express Scripts Customer Service Department toll free at 1-888-201-5853 or the Pharmacy Help Desk at 1-800-235-4357. You may also call either of these numbers or visit the Express Scripts website (www.express-scripts.com) to help locate the Express Scripts pharmacy nearest you.

COVERED DRUGS

1. Federal Legend prescription drugs.
2. Drugs requiring a prescription under the applicable state law.
3. Diabetic supplies (except for alcohol wipes and glucose monitors).
4. Insulin syringes.
5. Injectable insulin.
6. Contraceptive devices.

EXCLUDED DRUGS

1. Non-Legend drugs other than insulin.
2. Therapeutic devices or appliances, support garments and other non-medical substances.
3. Drugs intended for use in a physician's office or another setting other than home use.
4. Investigational or experimental drugs; including compounded medications for non-FDA approved use.
5. Prescriptions which an eligible person is entitled to receive without charge from any workers' compensation laws, or any municipal, state or federal program.
6. Rogaine.
7. Smoking cessation products.
8. Anorexiant.
9. Drugs used for treatment of chemical dependency or alcoholism.
10. Impotence drugs.
11. Legend homeopathic products.
12. Prescription medications that have over-the-counter (OTC) equivalents.
13. Over-the-counter (OTC) products.

Prior Authorization

In some instances any individual or class of medications may require prior authorization by Express Scripts to ensure that the following coverage criteria are met:

1. The prescription is for the treatment of a medical condition;
2. There is sufficient evidence to draw conclusions about the effect of the prescription on the medical condition being treated and on your health outcome;
3. The expected beneficial effects of the prescription outweigh the expected harmful effects;
4. The prescription represents the most cost-effective method to treat the medical condition.

As of the printing of this booklet the following are currently covered only with prior authorization by Express Scripts:

1. Growth hormones
2. Tretinoin (over the age of 25)
3. Botox

SPECIALTY MEDICATIONS

Due to the emergence of biotechnology agents to treat certain disease states that are high in costs and require the expertise and oversight by an industry leader in pharmacy benefit management (referred to as "Specialty" drugs), the Trustees approved an Express Scripts program that coordinates the authorization and delivery of these Specialty medications through its subsidiary CuraScript Pharmacy. **This part of the overall prescription benefit program applies to Specialty drugs only (primarily self-injectables but also includes some oral and inhaled drugs as well). Normal medications should continue through the Express Scripts retail or mail order programs.** The first Specialty medication should be filled through Express Scripts but after that the CuraScript program must be used for that same medication. Once CuraScript identifies your having received a Specialty medication through an Express Scripts network pharmacy, they will correspond with you to help you transfer into this new program.

Through CuraScript, medication and supplies necessary for administration will be delivered to your home or your doctor's office within 72 hours after receipt of a prescription requiring no additional information from the physician to process the order or within 24 hours prior to the next injection date.

This program provides access to a staff of pharmacists, nurses and patient care coordinators who are specialists in these types of medications and the conditions those medications treat. Also available is educational support or home instruction information. Ancillary supplies such as syringes and needles are provided at no charge.

Following is a current CuraScript list of Specialty Drugs (this list is subject to change and from time to time may include drugs that are not covered by the Major Medical Plan). If you happen to identify a medication on this list that you are currently taking you should expect notification from CuraScript after your first Specialty medication filled on or after February 1, 2005 through an Express Scripts network pharmacy. The CuraScript phone number is (866) 848-9870 should you or your physician wish to speak directly with a CuraScript pharmacist.

You might also wish to supply a copy of this section to your physician if you think you might be affected by this program.

If you have any questions about this program we urge you to call the Trust Fund Office at (562) 463-5065. Other phone numbers available to you are (888) 201-5853 for the Express Scripts Customer Service Department or you can call the Express Scripts Pharmacy Help Desk at (800) 235-4357.

CURASCRIPT SPECIALITY DRUG LIST

ANTICOAGULANT

Arixtra
Fragmin
Innohep
Lovenox
Refludan

BLOOD CELL DEFICIENCY

Aranesp
Epogen
Leukine
Neulasta
Neumega
Neupogen
Procrit

CANCER

Abraxane
Adriamycin
Adrucil
Alferon N
Alimta
Alkeran
Aredia
Arranon
Avastin
Bexxar
Bicnu
Blenoxane
Bleomycin Sulfate
Busulfex
Campath
Camptosar
Carboplatin
Cerubidine
Cisplatin
Cladribine
Cosmegen
Cyclophosphamide
Cytarabine
Cytosan
Dacarbazine
Dacogen
Daunorubicin HCL
Daunaxome
Depocyt
Dexrazoxane
Doxil
Doxorubicin HCL

DTIC-Dome IV
Eligard
Elitek
Ellence
Eloxatin
Elspar

CANCER cont.

Epirubicin
Eribitux
Ethyol
Etopophos
Etoposide
Floxuridine
Fludara
Fludarabine Phosphate
Fluorouracil
Fudr
Gemzar
Gleevec
Herceptin
Hycamtin
Idamycin PFS
Idarubicin HCL
Ifex
Ifex/Mesnex
Ifosfamide
Ifosfamide/Mesna
Intron A
Iressa
Ixempra
Kepivance
Leucovorin Calcium
Leuprolide Acetate
Leustatin
Lupron
Mesna
Mesnex
Methotrexate
Mitomycin
Mitoxantrone HCL
Mustargen
Mutamycin
Mylotarg
Navelbine
Nexavar
Nipent
Novantrone
Oncaspar

Ontak
Onxol
Paclitaxel
Pamidronate Disodium
Paraplatin
Photofrin
Plenaxis
Proleukin
Revlimid
Rituxan
Roferon-A
Sprycel
Sutent

CANCER cont.

Tarabine PFS
Tarceva
Taxol
Taxotere
Temodar
Thalomid
Theracys
Thiotepa
Thyrogen
Toposar
Torisel
Trelstar
Trisenox
Tykerb
Vantas
Vectibix
Velcade
Viadur
Vidaza
Vinblastine Sulfate
Vincristine Sulfate
Vinorelbine Tartrate
Vumon
Xeloda
Zanosar
Zevalin
Zinecard
Zoladex
Zolinza
Zometa

ENDOCRINE DISORDERS

DDVAP
Desmopressin Acetate
Octreotide Acetate

Sandostatin
Somatuline
Depot

ENZYME DEFICIENCIES

Adagen
Aldurazyme
Ceredase
Cerezyme
Elaprase
Fabrazyme
Myozyme
Naglazyme
Orfadin
Zavesca

GROWTH DEFICIENCY

Genotropin
Geref
Diagnostic
Humatrope
Increlex
Norditropin
Nutropin
Omnitrope
Saizen
Serostim
Somavert
Tev-Tropin
Zorbtive

HEMOPHILIA

Advate
Alphanate
Alphanine SD
Bebulin VH
Immuno
Benefix
Feiba VH
Immuno
Helixate FS
Hemofil M
Humate-P
Koate-DVI
Kogenate FS
Monarc-M
Monoclote-P

Mononine
Novoseven
Profilin SD
Recombinant
Refacto

HEPATITIS B

Bayhep B
Hepagam B
Hyperhep S/D
Nabi-HB

HEPATITIS C

Copegus
Infergen
Pegasys
Peg-Intron
Rebetol
Ribapak
Ribasphere
Ribatab
Ribavirin

IMMUNE DEFICIENCY

Actimmune
Carimune
Cytogam
Flebogamma
Fuzeon
Gamastan S/D
Gammagard
Gamunex
Hyperrab S/D
Hyperrho S/D
Immune Globulin
Imogam Rabies-HT
Michogam
Octagam
Polygam S/D
Retrovir
Rhogam
Rhopylac
Varicella-Zoster Imm
Globulin
Vivaglobin
Winrho SDF

(continued on following page)

CURASCRIPT SPECIALITY DRUG LIST (Continued)

<p>INFERTILITY Bravelle Cetrotide Chorionic Gonadotropin Follistim AQ Ganirelix Acetate Gonal-F Luveris Menopur Novarel Ovidrel Pregnyl Progesterone Repronex</p>	<p>MULTIPLE SCLEROSIS Acthar H.P. Avonex Betaseron Copaxone Rebif Tysabri</p> <p>OPHTHALMIC CONDITIONS Healon Lucentis Macugen Provisc Visudyne</p>	<p>TRANSPLANT Atgam Cellcept Cyclosporine Orthoclone Okt-3 Prograf Sandimmune Simulect Thymoglobulin Zenapax</p>
<p>INFLAMMATORY CONDITIONS Amevive Enbrel Humira Kineret Orencia Raptiva Remicade</p>	<p>OSTEOARTHRITIS Euflexxa Hyalgan Orthovisc Supartz Synvisc</p>	
<p>IRON TOXICITY Deferoxamine Mesylate Desferal Exjade</p>	<p>OSTEOPOROSIS Boniva Forteo Reclast</p>	
<p>MISCELLANEOUS SPECIALTY CONDITIONS 8-Mop Apokyn Botox Ceprotin Implanon Mirena Myobloc Natrecor Panretin Prialt Rilutek Soliris Supprelin LA Vivitrol Xyrem</p>	<p>PULMONARY HYPERTENSION Flolan Letairis Remodulin Revatio Tracleer Ventavis</p> <p>RESPIRATORY CONDITIONS Aralast Prolastin Pulmozyme Tobi Xolair Zemaira</p>	
	<p>RSV PREVENTION Synagis</p>	

Please Note: The drug list is provided as a guide and is updated periodically based on information from Express Scripts. For precise details related to your specialty drug benefit, please call CuraScript customer service at 866.848.9870.

BLOOD GLUCOSE MONITORING PROGRAM

Program Description/Goal:

The Blood Glucose Monitoring Program encourages members to use a glucose-monitoring device in the management of their diabetes. The program offers a free blood glucose monitoring kit to applicable members. This offer is made available by Lifescan Inc. and Roche Diagnostics. At no time will Express Scripts make individually identifiable patient information related to this program available to any manufacturer.

Scope/Clinical Rationale:

The American Diabetes Association recommends people with diabetes monitor their blood sugar to make sure their diabetes is well managed. Checking blood sugar is an important way to see how the body handles food, activity, medications, stress and illness.

Client Exclusions:

This offer is not available to plans or members who are entitled to benefits under Medicare, Medicaid or other state or federal health care programs.

Detail Criteria:

For this program, members are selected if they receive medications typically used to manage diabetes (insulin and/or oral antidiabetic prescriptions), and are *either* not currently using blood glucose meter test supplies *or* are using non-prescription blood glucose meter test supplies.

If you or your doctor would like more information about this program please call Express Scripts directly at (888) 201-5853 or (800) 235-4357.

VISION CARE BENEFITS PROVIDED THROUGH VISION SERVICE PLAN (VSP) FOR MAJOR MEDICAL PLAN PARTICIPANTS

This Vision Care Plan features an extensive network of Doctors to provide professional vision care for persons covered under the Major Medical Plan. This coverage assures the finest quality professional care and eyewear, at a uniform cost.

WHAT ARE THE BENEFITS

Vision Exam

A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities.

Lenses

The VSP Doctor will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The Doctor also verifies the accuracy of the finished lenses.

Frames

VSP offers a wide selection of frames. However, if you select a frame which costs more than the amount allowed, there will be an additional charge.

Contact Lenses

When patients choose contact lenses, VSP will make an allowance toward their cost in lieu of eyeglasses (lenses and frames) for that eligibility period, as outlined under, "HOW OFTEN ARE SERVICES AVAILABLE?"

HOW MUCH DO I PAY

STEP ONE. When you are ready to obtain vision care services, call your VSP doctor. If you need assistance in locating a VSP doctor, call VSP at (800) 877-7195.

STEP TWO. When making an appointment, identify yourself as a VSP member. The VSP doctor will ask for the covered member's identification number (usually the last four digits of your social security number). The VSP doctor will contact VSP to verify your eligibility and plan coverage. The doctor will also obtain authorization for services and eyewear. If you are not eligible, the VSP doctor will notify you.

STEP THREE. At your appointment, the VSP doctor will provide an eye exam and determine if eyewear is necessary. If so, the VSP doctor will coordinate the prescription with a VSP-approved, contract laboratory. The VSP doctor will itemize any non-covered charges and have you sign a form to document that you received services. VSP will pay the doctor directly for covered services and eyewear. You are responsible for paying the doctor any applicable copayment(s), and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a participating doctor from VSP's network assures direct payment to the doctor and guarantees quality services and eyewear.

WHAT IF I DON'T USE A VSP DOCTOR?

More than 90% of VSP patients receive services from VSP doctors, although you may select any licensed vision care provider for services. Your reimbursement schedule does not guarantee full payment, nor can VSP guarantee patient satisfaction, when services are obtained from an out-of-network provider.

Follow these steps if you obtain services and/or eyewear from an out-of-network provider:

1. Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of eye exam, lens type and frame.
2. Send a copy of the itemized bill(s) to VSP. The following information **must** also be included in your documentation:
 - (a) Member's name and mailing address.
 - (b) Member's identification number (usually the last four digits of your Social Security number).
 - (c) Member's group name (the O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund).
 - (d) Patient's name, relationship to member and date of birth.

You may submit the above information on a HCFA -1500 form or any generic insurance claim form that may be available from your out-of-network provider upon request.

Please mail the itemized bill(s) and form to the following address:

VSP
P.O. Box 997105
Sacramento, California 95899-7105

Please note that claims for reimbursement must be filed within six months of the date services were completed.

WHO IS ELIGIBLE?

Available to all members and their dependents covered by a collective bargaining agreement providing VSP vision care, except those who are covered under the Kaiser Foundation Health Plan who have vision care at Kaiser facilities.

HOW OFTEN ARE SERVICES AVAILABLE?

STANDARD EYE EXAM AND GLASSES

Eye Exam:	Once each 12 months*
Lenses:	Once each 24 months*
Frame:	Once each 24 months*

* *From your last date of service.*

LENSES AND FRAME

VSP covers a wide selection of frames, but not all frames will be covered in full. When a patient selects cosmetic options or a frame that exceeds the plan's allowance, these additional charges are administered at VSP's preferred member pricing. Please consult your VSP doctor about lens options which may be cosmetic in nature, and may result in additional costs.

CONTACT LENSES

Contact lenses may be provided instead of glasses. The standard eye exam is covered in full, less any applicable copayment. An allowance will be provided toward the contact lens evaluation exam, fitting costs, and materials. Any costs exceeding the allowance are the patient's responsibility.

WHAT ARE THE LIMITATIONS?

OPTIONS

This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge:

1. Blended lenses.
2. Contact lenses (except as noted elsewhere herein).
3. Oversize lenses.
4. Progressive multifocal lenses.
5. Photochromic or tinted lenses other than Pink 1 or 2.
6. Coated or laminated lenses.
7. A frame that exceeds the plan allowance.
8. Certain limitations on low vision care.
9. Cosmetic lenses.
10. Optional cosmetic processes.
11. UV protected lenses.

NOT COVERED

The following professional services or materials are not covered. Discounts may apply to some items.

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano lenses (non-prescription).
3. Two pair of glasses in lieu of bifocals.
4. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
5. Medical or surgical treatment of the eyes.
6. Corrective vision services, treatments, and materials of an experimental nature.

Savings on Other Benefits

VSP doctors offer valuable savings including a 20% discount on non-covered pairs of prescription glasses (lenses and frames). For example, you may wish to purchase a second pair of glasses at your own expense in addition to your already covered first pair of glasses or contact lenses. You can also save 15% off the cost of your contact lens exam when you receive contact lens services from VSP (this discount does not apply to the contact lenses).

LIFE INSURANCE and AD&D BENEFIT SUMMARY

Your Plan at a Glance:

Life and Accidental Death & Dismemberment (AD&D) Summary

Basic Life and AD&D

Basic Life	Basic Life Insurance coverage is provided to you at no cost by O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund in the amount of \$12,500.
Basic AD&D	Basic AD&D Insurance coverage is provided to you at no cost by O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund in the amount of \$12,500. Basic AD&D pays in the event of your accidental death or dismemberment. The AD&D benefit is paid in addition to your basic life insurance.

<p style="text-align: center;">Accidental Death & Dismemberment Benefit Schedule</p>	<p>Loss Percentage payment of the scheduled amount (\$12,500) is:</p> <p>Loss of Life 100%</p> <p>Loss of sight in both eyes 100%</p> <p>Loss of one hand and sight in one eye 100%</p> <p>Loss of one foot and sight in one eye 100%</p> <p>Quadriplegia 100%</p> <p>Paraplegia 50%</p> <p>Hemiplegia 50%</p> <p>Loss of one hand 50%</p> <p>Loss of one foot 50%</p> <p>Loss of one eye 50%</p> <p>Loss of sight of one eye 50%</p> <p>Loss of speech 25%</p> <p>Loss of hearing 25%</p>
<p style="text-align: center;">Benefit Reduction Life</p>	<p>Coverage terminates at retirement</p>
<p style="text-align: center;">Eligibility</p>	<p>All Active Employees of Contributing Employers whose employment is the subject of a Collective Bargaining Agreement by and between the Contributing Employers and the Office and Professional Employees International Union Locals 30 & 537</p>

The following exclusions apply to your Accidental Death & Dismemberment coverage: Suicide or attempted suicide while sane or insane; War or act of war; Disease, bodily or mental infirmity, or infection (except bacterial infection from a visual accidental injury); Intentional self-inflicted injury; Drugs unless prescribed by physician; Driving while intoxicated as defined by the applicable state laws where

the loss occurred; Commission of felony, crime or assault; Flight, unless fare paying passenger on commercial flight.

Life and Accidental Death & Dismemberment coverages are underwritten by Unimerica Insurance Company, 6300 Olson Memorial Hwy, Golden Valley, MN 55427. This is a summary of benefits and does not include all plan provisions and exclusions. Late applicants are subject to Evidence of Insurability.

This is an overview of your benefits. The contract will govern actual benefits. The Company reserves the right to make future changes.

MEDICAL AND DENTAL EXPENSE BENEFITS COORDINATION

Medical and Dental Expense Benefits are subject to the following Coordination of Benefits provision.

"Coordination" means that if the covered person is entitled to benefits under any plan (Plan defined below) which will pay part or all of the expenses incurred for services and supplies for treatment of an illness or injury, the amount of benefits payable by this Plan and any other Plans will be coordinated so that the aggregate amount paid will not exceed the amount that would be paid if this Plan were the primary payer. The O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund payment will not exceed the amount which would have been paid if there were no other Plan involved.

The term "Plan" includes the benefits payable under this Plan and any other plan providing benefits or services for or by reason of medical or dental care treatment, which benefits or services are provided by: (a) group, blanket or franchise insurance coverage, (b) service plan contracts, group practice, individual practice and other prepayment coverage, (c) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (d) any coverage under governmental programs, and any coverage required or provided by any statute.

If a person covered under this Plan is also covered under another Plan or Plans and, as a result, has two or more coverages, and the other Plan has a similar duplication of coverage provision, rules set out in this Section establish the Plan that will pay benefits first and the Plan that will pay the benefits not paid by the first Plan.

SPECIFIC CONDITIONS AND HOW THEY ARE APPLIED IN PAYMENT OF CLAIMS FOLLOW

Active/Retired or Laid-Off Employee

The Plan covering a person as an employee who is neither laid-off nor retired (or as that person's dependent) pays benefits first. The Plan covering that person as a laid-off or retired employee (or as that person's dependent) pays benefits second.

Employee/Dependent

The Plan covering the person as an employee pays benefits first. The Plan covering the person as a dependent pays benefits second.

Dependent Children of Parents not Separated or Divorced

The Plan covering the parent whose birthday falls earlier in the year pays first. The Plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the Plan which covered the parent longer pays first. The Plan which covered the other parent for a shorter time pays second. The year of birth is not relevant in applying this rule.

However, if one coordinating Plan uses a birthday rule and the other uses a male/female rule, both Plans will follow the male/female rule.

Dependent Children of Separated or Divorced Parents

When parents are separated or divorced, neither the male/female nor the birthday rules apply. Instead:

1. The Plan of the parent with custody pays first.
2. The Plan of the spouse of the parent with custody (the step-parent) pays next; and
3. The Plan of the parent without custody pays last.

However, if the divorce decree places the financial responsibility for the child's health care expense on one of the parents, then the Plan covering that parent pays benefits first.

Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the Plan covering a person longer pays first. The Plan covering that person for the shorter time pays second.

EXCEPTION

The Plan which covers as an active employee or as a dependent of an active employee will pay before the Plan which covers such person as a retired employee or as a dependent of a retired employee, regardless of the length of time each Plan has covered such person.

EXCEPTIONS FOR PERSONS COVERED BY MEDICARE

Coordination with Medicare

When you or your dependent are eligible for both Medicare benefits and benefits under this Plan, this Fund will coordinate benefits with Medicare.

Employee

For Employees and dependents eligible for Medical Benefits, this Fund will be, in most cases, the primary payor with Medicare paying on a secondary basis. (Refer to definition of Dependent on page 12).

COORDINATION WITH PRE-PAID PLANS (MEDICAL AND DENTAL)

If your spouse is covered under another Fund or form of health insurance as an employee under a pre-paid plan and as a dependent under the O.P.E.I.U. Locals 30 & 537 Health and Welfare Trust Fund, no benefits will be payable under this Fund if your spouse does not receive treatment from the pre-paid plan. If your spouse seeks or receives treatment from the pre-paid plan, the secondary coverage under this Fund will coordinate benefits in accordance with the above indicated provisions.

If you are covered as an Employee under this Fund and as a dependent under a pre-paid plan sponsored by your spouse's employer, you may receive treatment from either your own provider or privately selected hospital or from the pre-paid provider or hospitals. If you receive treatment through the pre-paid plan, your primary coverage under this Fund will pay its normal benefits for any expenses that you are legally obligated to pay.

Obtaining Information

Information necessary to the administration of this Coordination of Benefits Provision will be required of the employee at the time a claim is submitted.

The Fund shall have the right to request an Employee and/or an Employee's dependent spouse to sign a consent authorizing the Fund to release to, or obtain from, another Plan any information necessary to the implementation of its coordination of benefits provision. If requested, no applicable claims shall be processed until the employee or dependent spouse gives such consent.

Right of Recovery

Whenever payments which should have been made under this Plan, in accordance with this coordination of benefits provision, have been made under any other Plans, the Fund shall have the right to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of the provision, and amounts so paid shall be deemed to be benefits paid under this Plan, and, to the extent of such payments, the Fund shall be fully discharged from liability under this Plan.

Whenever payments have been made by the Fund with respect to all allowable expenses in a total amount, at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of this coordination of benefits provision, the Fund shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Fund shall determine: any

persons to, or for, or with respect to, whom such payments were made, any insurance companies or any other organization.

Assignment and Reimbursement to Fund of Benefit Payments for Accident or Injury

If a Participant or one claiming through him, e.g., heirs, beneficiaries, personal representatives, or estate, etc., may have payments inure to his benefit, from whatever source and whether completed or to occur in the future, in whole or in part for injury or illness for which benefits are otherwise provided by the Fund, such benefits shall be limited to a maximum of \$2,500 and any benefits exceeding \$2,500 are excluded from coverage by the Plan.

Audit of Doctor and Hospital Bills

For your protection, and to ensure that proper payment is made, the Fund may require doctors and hospitals to submit to an audit of billings made for care provided. The Fund may require employees and dependents to authorize such audits, and if requested by the Fund, the granting or permission to audit doctor and hospital bills shall be a condition precedent to payment of such bills.

GENERAL PROVISIONS

No Assignment of Benefits

Benefits paid hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, any eligible Employee may direct that benefits due him/her be paid to an institution in which he/she or his/her eligible Dependent is hospitalized or to any other provider of medical or dental care services or supplies in consideration for medical, hospital or dental care services rendered or to be rendered.

Disclaimer

The fee-for-service medical benefits described in this booklet are not insured by any contract of insurance and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Fund collected and available for such purposes.

Amendment and Termination

In order that the Fund may carry out its obligation to maintain within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time:

1. to terminate or amend the amount or eligibility conditions with respect to any benefits even though such termination or amendment affects claims which have already accrued;
2. to terminate the Plan even though such termination affects claims which have already accrued;
3. to alter or postpone the method of payment of any benefit; and
4. to amend or rescind any other provisions of the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund, 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

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. 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 administrator may make a reasonable charge for the copies.
3. 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 annual report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have followed and exhausted the Plan's Claims and Appeals Procedures starting on page 7, you may file suit in state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, and you have requested the Board of Trustees to review your situation and you are still dissatisfied with their decision, 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 legal fees. If you lose, the court may require you to pay these costs and legal fees; for example, if the court finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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.

NOTES