SANTA MONICA UNITE HERE HEALTH BENEFIT TRUST FUND

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

Effective July 1, 2021

Administrative Office
Benefit Programs Administration
1200 Wilshire Boulevard, 5th Floor
Los Angeles, California 90017

INTRODUCTION

Dear Eligible Employees:

The Santa Monica UNITE HERE Health Benefit Plan (the "Plan") is maintained by the Santa Monica UNITE HERE Health Benefit Trust Fund (the "Fund") as a multiemployer plan. The Fund was established in 1953, as a result of collective bargaining between Employers and the predecessor to UNITE HERE Local 11.

Employers contribute to the Fund as required by Collective Bargaining Agreements and the Agreement and Declaration of Trust Providing for the Santa Monica UNITE HERE Health Benefit Trust Fund (the "Trust Agreement"). Appointed by the Union and certain Employers, the Board of Trustees of the Fund design, administer, and maintain the Plan.

The Plan offers eligible Employees and their Dependents medical, prescription drug, dental, vision, member assistance program (MAP), life insurance, and accidental death and dismemberment benefits.

- The Martin Luther King Community Healthcare Program (the "MLK Program") benefits are provided directly by the Fund and are described in this booklet.

- The Health Net HMO Plan, the Kaiser Permanente HMO Plan, United Concordia Dental Care Plan, Delta Dental PPO Dental Plan, Vision Service Plan, and Member Assistance Program (MAP) benefits are provided through contracts between the Fund and various Health Maintenance Organizations ("HMOs") and insurance companies. These benefits are described in separate documents issued by the HMOs and insurance companies. For your convenience, brief summaries of these benefits are included in this booklet; however, detailed information can be found in the official insurance company documents that describe the benefits.

- The Prescription Drug Program is provided by Express Scripts under a contract with the Fund. All outpatient prescriptions, regardless of the medical plan in which you are enrolled, must be obtained from an Express Scripts network pharmacy or, if applicable, through Express Script's mail order program.

- Life Insurance and Accidental Death & Dismemberment benefits are provided directly by the Fund and are described in this booklet.

This booklet, together with the Trust Agreement and other governing plan documents, constitutes the Fund's Plan Document. With respect to the Health Net and Kaiser Permanente HMO plans, dental, vision, and MAP benefits, this booklet is not intended to give Employees and their Dependents any substantive rights to benefits that are not provided by the insurance contracts, Evidence of Coverage, and other governing documents issued by the respective insurance company or HMO.

We are pleased to welcome you to our Plan. Please contact our Administrative Office if you have questions or need any assistance.

Sincerely,

BOARD OF TRUSTEES of the
Santa Monica UNITE HERE Health Benefit Trust Fund

Important information, forms, and documents are *available on the internet at:*
www.santamonicauniteherefunds.org

FOR HELP AND INFORMATION

When you need information, please review this Summary Plan Description. If you need further help, call the Fund's service providers listed under Whom to Contact in the following Reference Chart:

REFERENCE CHART

WHOM TO CONTACT	INFORMATION NEEDED
Administrative Office of the Fund (Benefit Programs Administration ("BPA")) (866) 345-5189 (562) 463-5075 Address: 1200 Wilshire Boulevard, 5th Floor Los Angeles, California 90017	Call the Administrative Office for: • Eligibility status and questions; • Medical and dental enrollment; • Open enrollment; • COBRA administration; • Beneficiary designation for Life Insurance; • General help.
Martin Luther King Community Healthcare Program (MLK Program) To make an appointment with a MLK Primary Care Provider: (424) 529-6755 For other claims related questions, prior authorizations, or customer service, call Design Benefits Administrators (DBA): **Customer Service: (833) 961-3021**	Call DBA for: • Benefit questions about the MLK Program; • ID Cards (for MLK Program only); • Help finding a doctor; • Help with prior authorization or referrals; • Claims for benefits under the MLK Program; • Health Appeals under the MLK Program.
Life Insurance/ Accidental Death & Dismemberment **Call:** The Administrative Office (866) 345-5189 or (562) 463-5075	Call the Administrative Office to: • File a claim for benefits; • Make or change your beneficiary designation; • Get information about benefits.
Appeals **Call:** The Administrative Office (866) 345-5189; or (562) 463-5075 Call: Design Benefit Administrators ("DBA") for Appeals under MLK Program: (833) 961-3021	Call the Administrative Office to: • Make a claim for benefits; • Request a review of a denial of eligibility; • For questions about filing an appeal; Call DBA if the appeal pertains to benefits under the MLK Program.

IMPORTANT NOTICE TO EMPLOYEES AND DEPENDENTS

From time to time, the Administrative Office may mail you updated materials (such as a "Summary of Material Modifications") in order to inform you of changes to Plan benefits. It is important that you keep all literature received with this Summary Plan Description ("SPD") and note the affected sections.

The Trustees have full discretionary authority to determine eligibility for benefits; to administer, apply, and construe the terms of the Plan and the SPD; to interpret any other Plan documents; and to decide all matters arising in connection with the operation or administration of the Fund. For benefits provided under insurance contracts (e.g., HMO medical benefits, dental insurance, vision benefits, and MAP benefits), the insurer has authority to make benefits decisions.

Any interpretation of the Plan, and any determination of benefits under the Plan, made by the Trustees shall be final and binding as to all persons, including Employees, Dependents, Employers, and the Union.

In accordance with the terms of the Trust Agreement, the Board of Trustees reserves the right to amend or terminate the Plan at any time. Plan amendments may result in reductions in benefits or changes in eligibility rules. In addition, the Plan may be terminated upon the nonrenewal of all Collective Bargaining Agreements between UNITE HERE Union Local No. 11 and Participating Employers that require such Employers to make contributions to the Trust Fund.

In the event of any discrepancy or ambiguity, the language of any contract or insurance policy under which Plan benefits are provided will be controlling over any provisions of this Summary Plan Description and Plan Document.

TABLE OF CONTENTS

TABLE OF CONTENTS
(Continued)

TABLE OF CONTENTS
(Continued)

TABLE OF CONTENTS
(Continued)

I. GENERAL DEFINITIONS

When the following terms are used in this booklet, they have the meanings described below:

1. **Administrative Office**. The administrative office of the Santa Monica UNITE HERE Health Benefit Trust Fund.

2. **Collective Bargaining Agreement**. A labor agreement between the Union and an Employer that requires the Employer to contribute to the Fund, and by which the Employer agrees to be bound by the terms of the Trust Agreement; and any extensions, modifications or renewals of such labor agreement.

3. **Dependent**. A person who is eligible for benefits under the Plan as:

   A. Your legal spouse or Domestic Partner, as defined under the Plan; or

   B. Your child or your Domestic Partner's child who is less than 26 years of age, including a stepchild, a child who has been legally adopted or lawfully placed with you for adoption, or a child for whom you or your Domestic Partner have been appointed legal guardian.

4. **Domestic Partner**. A Domestic Partner of the same or opposite sex as an eligible Employee may be eligible for benefits under the Plan. To qualify, both the Employee and his/her Domestic Partner must submit a completed Declaration Form, which can be obtained from the Administrative Office. Among other things, the Declaration requires both persons to declare that they (i) are at least 18 years of age, (ii) hold themselves out as having a committed relationship, (iii) have lived together for at least 6 months, currently live together, and plan to continue living together indefinitely, (iv) have had no other spouse or Domestic Partner within the past 6 months, (v) are not related to each other to a degree that would prevent them from marrying, and (vi) have registered their union officially if the jurisdiction in which they live provides for such registration.

   To enroll a Domestic Partner for benefits, please contact the Administrative Office for an Application, a Declaration of Domestic Partnership Form, and additional information on enrollment requirements.

5. **Employee**. A person who works in a position that is covered by a Collective Bargaining Agreement or a Participation Agreement and for whom contributions are required to be made to the Fund.

6. **Employer or Participating Employer**. Any employer that has entered into a Collective Bargaining Agreement or a Participation Agreement that requires contributions to the Fund.

7. **Fund**. The Santa Monica UNITE HERE Health Benefit Trust Fund.

8. **Hours Worked or Hours**. Each hour worked by or paid to an Employee for which contributions are required under a Collective Bargaining Agreement or Participation Agreement and actually received by the Fund.

9. **Initial Eligibility Date**. The date that an Employee and his or her Dependent(s) first become eligible for benefits under the Plan.

10. **Minimum Required Hours**. If you are in the Legacy Plan, Minimum Required Hours are 60 Hours Worked. If you are in the Hotel Plan, Minimum Required Hours are 80 Hours Worked, unless you are a Banquet Server. Minimum Required Hours for Banquet Servers are 60 Hours.

11. **Participant**. A person eligible for benefits under the Plan, whether as an Employee or as the Dependent of an Employee. In addition, with respect to medical benefits (including prescription drug, vision, and MAP benefits), the eligible Employee or Dependent must be enrolled in one of the Fund's HMO medical plans (Health Net or Kaiser HMO) or the Martin Luther King Community Healthcare Program. For dental insurance, the eligible Employee or Dependent must be enrolled in one of the Fund's dental plans (the Dental Care Plan by United Concordia or the Delta Dental PPO Plan).

12. **Participation Agreement**. An agreement between the Fund and an Employer or the Union, other than a Collective Bargaining Agreement, that requires an Employer or the Union to make contributions to the Fund and be bound by the terms of the Trust Agreement.

13. **Plan**. The Santa Monica UNITE HERE Health Benefit Plan.

14. **Spouse**. The individual who is legally married to the Employee, as recognized under the laws of the state or jurisdiction in which the marriage was entered into.

15. **Trust Agreement**. The Agreement and Declaration of Trust Providing for the Santa Monica UNITE HERE Health Benefit Trust Fund.

16. **Trustees**. The Board of Trustees of the Santa Monica UNITE HERE Health Benefit Trust Fund.

17. **Union**. UNITE HERE Union Local 11, AFL-CIO.

18. **You**. Unless otherwise specified, the words "you," "your," and "yours" refer to an Employee.

II. ELIGIBILITY RULES

1. How You Become Eligible

You must satisfy certain initial eligibility requirements before you become eligible for coverage from this Fund. The initial and continuing eligibility rules that apply to you depend on whether you are in the Legacy Plan or the Hotel Plan. For information about how to determine which of these Plans that you are in, call the Administrative Office at (866) 345-5189.

A. Initial Eligibility Date for Participants in Legacy Plan

You and your Dependents will become eligible for Plan benefits on your "Initial Eligibility Date."

If you are in the Legacy Plan, your Initial Eligibility Date is the first day of the third month following a period of 3 consecutive months, during which you worked at least 60 Hours in each of the 3 consecutive months for an Employer in a position covered by a Collective Bargaining Agreement **and** the Employer made the required contributions to the Fund.

For example, if you started working in January and worked at least 60 Hours per month in January, February, and March, you and your Dependents would become eligible for benefits on June 1, which is the first day of the third month after March. In this example, June 1 would be your Initial Eligibility Date.

Other eligibility rules may apply if:

a. You are working for an Employer at the time it signs its first Collective Bargaining Agreement.

b. You were previously eligible under another UNITE HERE Union health and welfare plan.

c. You are in the Fund's Hotel Plan.

B. Initial Eligibility Date for Participants in Hotel Plan

You and your Dependents will become eligible for Plan benefits on your "Initial Eligibility Date."

If you are in the Hotel Plan, your Initial Eligibility Date is the first day of the third month following a period of 5 consecutive months during which you worked at least 80 Hours (or 60 Hours for Banquet Servers) in each of the 5 consecutive months for an Employer in a position covered by a Collective Bargaining Agreement requiring contributions to the Hotel Plan **and** the Employer made the required contributions to the Fund.

For example, if you started working in January and worked at least 80 Hours (or 60 Hours for Banquet Servers) per month in January, February, March, April and May, you and your Dependents would become eligible for benefits on August 1, which is the first day of the third month after May. In this example, August 1 would be your Initial Eligibility Date.

Other eligibility rules may apply if:

a. You are working for an Employer at the time it signs its first Collective Bargaining Agreement.

b. You were previously eligible under another UNITE HERE Union health and welfare plan.

c. You are in the Fund's Legacy Plan (or you work for more than one contributing Employer, and at least one of your contributing Employers contributes to the Legacy Plan for your work).

To get coverage when you're first eligible, you should return your completed enrollment materials to the Administrative Office as soon as possible after you receive them.

2. Initial Enrollment

You will receive enrollment materials from the Administrative Office after you have been reported to the Fund as an Employee.

Coverage for you and your Dependent(s) will not be effective until you enroll. Enrollment in Life Insurance and Accidental Death & Dismemberment benefits, however, is automatic.

In order to enroll yourself and your Dependents in the Plan, you must return your enrollment materials to the Administrative Office within 90 days after your Initial Eligibility Date.

Note: For full benefits, you must complete two enrollment forms. Specifically, you must complete an enrollment form for the medical plan in which you are enrolling and for the dental plan in which you are enrolling. If you enroll for medical coverage, you will automatically be covered under the Prescription Drug Program administered by Express Scripts, MAP benefits through Beacon Health Options, and vision benefits through VSP.

- If you return your enrollment materials before your Initial Eligibility Date, your coverage will begin on your Initial Eligibility Date. *For example, if you return your enrollment materials before your Initial Eligibility Date of June 1, your coverage will begin on June 1.*

- If you return your enrollment materials after your Initial Eligibility Date, your coverage will begin on the first day of the month following the month in which you enroll. *For example, if you return your enrollment materials on June 15, which is after your Initial Eligibility Date of June 1, your coverage will begin on July 1.*

- **If you do not return the enrollment materials within ninety (90) days after your Initial Eligibility Date, you will not be able to enroll until the Plan's next annual Open Enrollment period** (see Section 6 of this Article II), unless you have a Special Enrollment opportunity (see Section 7 of this Article II).

To Enroll Your Dependents: You must complete your medical and/or dental enrollment forms and submit them to the Administrative Office, along with any required supporting documentation (including a marriage certificate for a Spouse; a Declaration of Domestic Partnership form for a Domestic Partner; and birth certificates for Dependent children), within the timeframes described above. *Under no circumstances will the Fund offer Dependent coverage only. You, the Employee, must be enrolled in order for your Dependents to be enrolled.* Once enrolled, you and your Dependents cannot disenroll or drop your medical coverage. You can choose to "opt out" of or drop your dental insurance and/or vision benefits through VSP.

You must notify the Administrative Office promptly of any change in your family status (such as marriage, divorce, death, or new children) or of your or your Dependents enrollment in Medicare. If a change in family status (such as a divorce) results in one or more of your Dependents no longer qualifying as a Dependent (for example, if you divorce, your spouse is no longer eligible for coverage from the Fund), you must notify the Administrative Office or you will be responsible for reimbursing the Fund for any benefits paid in error, including any insurance premiums the Fund pays to provide coverage for your dependent after he or she is no longer eligible for coverage.

YOU ARE NOT ALLOWED TO DISENROLL.

Once you enroll for coverage, you are not allowed to disenroll from (or drop) medical coverage. You will have medical coverage from the Fund as long you work enough Hours to earn Eligibility, and your enrolled Dependents will lose coverage only if they no longer satisfy the definition of Dependent (for example, if you get divorced, your former spouse would no longer qualify as your Dependent) or if you do not work enough Hours to maintain your eligibility. The only exception to this rule involves the situation where the Participant is eligible for Medicare and wants Medicare to be primary, as described on page 98.

3. How Your Eligibility Continues

Once your eligibility is established, you will remain eligible as long as you continue to have the Minimum Required Hours Worked each month for one or more Employers, and the Employer(s) make(s) contributions to the Fund as required by a Collective Bargaining Agreement or Participation Agreement.

Plan	Minimum Required Hours
Legacy Plan	60
Hotel Plan (except Banquet Servers)	80
Hotel Plan Banquet Servers	60

Here's How It Works: After your initial eligibility is established, Hours Worked during each month determine eligibility for the third following month, as shown in the following Eligibility Table:

ELIGIBILITY TABLE

If You Work Minimum Required Hours and Contributions are Made for The Month of	You Will Be Eligible for Benefits During
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

4. Employee Contributions

Some Participants are required to pay a share of the cost of coverage through monthly employee contributions.

A. No Employee Contributions for the Legacy Plan

The Fund does not require employee contributions for coverage under the Legacy Plan.

B. Employee Contributions for the Hotel Plan

The Fund requires Participants in the Hotel Plan to pay a monthly employee contribution for coverage under the Kaiser HMO Plan. The amount of the monthly employee contribution does not change based on family size. The current amount of the monthly employee contribution will be provided to you with your enrollment packet, and you will be notified of any changes.

There is no employee contribution if you are enrolled in the MLK Program or the Health Net Plan.

If you have enrolled in the Kaiser HMO Plan, and are eligible for coverage based on Hours Worked, you will *not* have coverage in a given month until you pay your employee contribution for that month.

If you have any question about employee contributions, including whether you are required to pay employee contributions, the amount you are required to pay, or whether your employee contributions are current, please contact the Administrative Office.

C. General Rules Pertaining To Employee Contributions

Generally, employee contributions are required to be paid by payroll deduction. You must sign a Payroll Deduction Authorization form to allow your Employer to withhold your employee contributions from your paycheck. There are a few exceptions, such as if you work for more than one contributing Employer or if your Employer is unable to withhold your employee contribution in one or more months.

Your employee contribution is generally withheld from your paycheck in the third month before the coverage month. Thus, for example, payroll deductions taken in February are expected to pay for May coverage.
If you are behind in your Employee contributions, the Administrative Office may temporarily increase your deduction to recover the amount you owe or it may send you a bill for the amount owed.
You must pay your employee contribution for each month that you are eligible for coverage under the Kaiser HMO Plan, regardless of whether you use benefits for that month. Thus, you cannot pick and choose which months to pay your employee contribution. Employee contributions are always applied to the earliest month for which employee contributions remain unpaid.

If your employee contribution is not paid timely for a given month, you will not have coverage for

that month until your payment is received and processed. The Administrative Office will then reinstate coverage retroactively to the extent permitted by Kaiser.

Employee contributions are due by the 15th of the month prior to the coverage month. For example, for coverage in May, your employee contribution must be received no later than April 15th.

If your employee contribution is late more than three times (or for more than three months) in a calendar year, your coverage will be terminated, and you will not be able to re-enroll for coverage until the next Open Enrollment, unless you have a Special Enrollment right.

For more information about the payment of employee contributions and the consequences of not paying timely, please contact the Administrative Office.

5. When Your Eligibility Ends

A. General Rule

Your eligibility, and Plan coverage for you and your Dependent(s), will end on the last day of the second month after the month in which you worked less than the Minimum Required Hours for an Employer making required contributions under a Collective Bargaining Agreement or Participation Agreement.

For example:

If You Worked Less Than the Minimum Required Hours in the Month of	Your Eligibility and Benefits Will Terminate On
January	March 31
February	April 30
March	May 31
April	June 30
May	July 31
June	August 31
July	September 30
August	October 31
September	November 30
October	December 31
November	January 31
December	February 28 or 29

If your coverage ends, you and/or your Dependents may be able to temporarily continue your Plan coverage through COBRA self-payments (see Article XIV, Section 1) or by using disability credits (see Section 8 of this Article II). In addition to these options for continuing coverage under the Plan, you may be able to enroll in an individual conversion plan through your HMO, in individual health coverage through a health insurance exchange (Covered

California), or in Medi-Cal. For more information about those options, visit www.coveredca.com or call (800) 300-1506.

B. Due to Late Payment or Non-Payment of Employee Contributions

If you are required to pay a monthly employee contribution for your coverage, and you do not timely pay your contribution, you will not have coverage until your payment is received and processed. Once you pay the contribution, the Administrative Office will reinstate your coverage retroactively. However, if you are in an HMO Plan, your coverage will be restored retroactively only to the extent permitted by your HMO.

If you pay your employee contribution late more than three times in a calendar year (or for more than three months), your coverage will be terminated completely, and you will be required to wait until the next Open Enrollment period to enroll for coverage, unless you have a Special Enrollment right.

For example, if you do not timely pay your employee contributions for February, April, July, and August, your coverage will end as of the end of the last coverage month for which you had both worked enough Hours to earn eligibility and paid your employee contributions. In the above hypothetical, your coverage would end on June 30, because June is the last month for which you earned eligibility and paid your monthly employee contribution.

C. Due to Employer's Withdrawal

Notwithstanding the General Rule described in subsection A, if your Employer's obligation to contribute to the Fund ceases or if your Employer no longer has an obligation to contribute to the Fund with respect to Employees at your worksite or in your bargaining unit, then coverage for you and your Dependent(s) ends on the last day of the last work month for which your Employer is required to contribute to the Fund on your behalf. Disability credits cannot be used to extend eligibility after your Employer has withdrawn from the Fund in whole or in part.

6. How Your Eligibility is Reinstated

If your eligibility ends, your eligibility will be reinstated if you again work the Minimum Required Hours in one of the first four calendar months after the month in which you last worked the Minimum Required Hours. Your reinstated eligibility will start on the first day of the third calendar month following the month in which you again work the Minimum Required Hours. If you do not work the Minimum Required Hours in one of the four calendar months mentioned above, you will not be able to reinstate your eligibility; instead, you must re-establish your initial eligibility as a new Employee (See "How You Become Eligible," at Article II, Section 1).

Examples: End and Reinstatement of Eligibility

A. Maria, an Employee enrolled in the Fund, had the Minimum Required Hours in January, but less than the Minimum Required Hours in February and March. She then works the Minimum Required Hours in April.

Result: Maria is eligible for benefits during April because she worked at least the Minimum Required Hours in January. Maria is not eligible for benefits during May and June, because she did not work the Minimum Required Hours in February and March. Maria is reinstated to be eligible for benefits in July, the third month following April, because she has Minimum Required Hours in one of the four calendar months (February, March, April, May) after January, the last month that she had Minimum Required Hours.

B. Franklin, an Employee enrolled in the Legacy Plan, had Minimum Required Hours in December, but he works less than the Minimum Required from January through April. Franklin returns to working more than the Minimum Required Hours per month in May, June, July, and August.

Result: Franklin's eligibility ends on the last day of March. Franklin does not have the Minimum Required Hours in any of the four months following December (January, February, March, April). Therefore, Franklin is required to re-establish initial eligibility under Section 1 of this Article II. Because Franklin has 60 Hours or more in three consecutive months (May, June, and July) after losing his eligibility, he is newly eligible for benefits beginning on October 1. (If Franklin was in the Hotel Plan, he would need 80 Hours in each of five consecutive months – from May through September - in order to be newly eligible for benefits beginning on December 1).

7. Open Enrollment

Open Enrollment is conducted at least once a year, usually during November and December, with any enrollment changes becoming effective the following January 1. During Open Enrollment, Employees may make the following changes:

- An Employee who is eligible for benefits, but did not enroll during the initial enrollment period, may enroll him or herself in the Plan, along with any Dependents.
- An Employee enrolled in the Plan, who did not previously enroll one or more Dependents, may enroll any eligible Dependents in the Plan.
- An Employee (and his or her Dependents) who has been enrolled in the Martin Luther King Community Healthcare Program for at least 12 consecutive months may switch to the Health Net Plan or the Kaiser HMO Plan, if the Employee is eligible to enroll in the Kaiser HMO Plan (see Article III, Section 1.C. for more information on eligibility requirements for Kaiser).

- An Employee (and his or her Dependents) enrolled in the Health Net Plan may switch to the Kaiser HMO Plan, if the Employee is eligible to enroll in the Kaiser HMO Plan (see Article III, Section 1.C. for more information on Kaiser's eligibility rules). Similarly, the Employee can enroll in the MLK Program, if the Employee lives within the MLK Program service area (see Article IV, Section 1. on the MLK Program service area).

- An Employee (and his or her Dependents) enrolled in the Kaiser HMO Plan may switch to the Martin Luther King Community Healthcare Program or the Health Net Plan.

- An Employee (and his or her Dependents) enrolled in the Dental Care Plan provided by United Concordia may switch to the Delta Dental PPO Plan, if the Employee is eligible to enroll in the Delta Dental PPO Plan (see Article III, Section 3.B. for more information on Dental Dental's eligibility rules). Similarly, an Employee (and his or her Dependents) enrolled in the Delta Dental PPO Plan may switch to the United Concordia Dental Care Plan.

Your changes must be in writing and submitted to the Administrative Office before the end of the Open Enrollment period.

In general, changes made during Open Enrollment will become effective on the following January 1st, provided that you continue to be eligible for benefits at that time. Any changes you make during Open Enrollment cannot be modified until the next Open Enrollment period, unless a Special Enrollment opportunity arises (see Section 7 of this Article II for more information on Special Enrollment).

8. Special Enrollment

Special Enrollment allows you, under certain situations, to (1) enroll yourself and/or your Dependent(s) in the Plan outside of Open Enrollment, even if you did not enroll when you were initially eligible and (2) switch your medical and/or dental plan choice to another plan option that is available to you and your Dependents without having to wait until Open Enrollment.

Special Enrollment is available only in the following circumstances:

- **Upon the Loss of Other Coverage.** If you did not enroll yourself or any of your Dependents in the Plan because you or your Dependent(s) had other health insurance or group health plan coverage, including coverage under Medi-Cal (or another state Medicaid program) or a state children's health insurance program (CHIP), and you or your Dependent(s) lose eligibility for that other coverage (or, if your other coverage was employer-provided group health coverage, and the employer stops its contributions toward the cost of the coverage), you may be able to enroll yourself and/or your Dependent(s) in the Plan.

Special Enrollment rights are triggered **when there is a loss of other coverage due to** your divorce or legal separation or the termination of your Domestic Partnership, the cessation of dependent child status (such as attaining the maximum age to be eligible as a dependent child under the other coverage), the death of your Spouse or Domestic Partner, the termination of employment or reduction in the number of hours of your Spouse's or Domestic Partner's employment, or the exhaustion of COBRA continuation coverage available through another group health plan. Special Enrollment rights do *not* apply when there is a loss of other coverage due to the failure to pay premiums on a timely basis, termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), or voluntarily dropping such other coverage.

In order to receive Special Enrollment rights for loss of other coverage, you must provide proof of the involuntary loss of other coverage. If you are the one losing other coverage, then you and all of your eligible Dependents will have Special Enrollment rights. If your Dependent is the one losing coverage, then you and that Dependent will have Special Enrollment rights.

- **Upon the Addition of a New Dependent.** If you acquire a new Dependent as a result of marriage, Domestic Partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your newly-acquired Dependent(s), plus your eligible Spouse or Domestic Partner (if applicable), in the Plan.

- **Upon Obtaining Eligibility for State Premium Assistance.** If you or any of your Dependents become eligible for a premium assistance subsidy under Medi-Cal (or another state Medicaid program) or under a state children's health insurance program (CHIP) with respect to coverage under the Plan, you may be able to enroll yourself and/or your Dependent(s) in the Plan.

Deadline for Requesting Special Enrollment. You must contact the Administrative Office to request Special Enrollment within 90 days after one of the following dates, as applicable: (1) the date you and/or your Dependent loses other coverage; (2) the date you acquire a new Dependent through marriage, Domestic Partnership, birth, adoption, or placement for adoption; or (3) the date you or your Dependent(s) are determined to be eligible for premium assistance.

Plan Coverage Start Date. If Special Enrollment is requested within this 90-day period, Plan coverage for you and/or your Dependent(s) will begin on the first day of the month after you request special enrollment, *with one exception*: if you request Special Enrollment within thirty (30) days after the date of a marriage, birth, adoption, or placement for adoption, Plan coverage will begin retroactively as of the date of the birth, adoption, or placement for adoption.

If you do not timely request Special Enrollment, you must wait until the next annual Open Enrollment period to enroll yourself and/or your Dependent(s), unless a different Special Enrollment event occurs beforehand. In addition, you must wait until Open Enrollment to enroll any Dependents who do not have Special Enrollment rights.

9. Extended Eligibility for Disability Credit

If, after becoming eligible, you are unable to work the Minimum Required Hours in a month because of an injury or sickness, as certified by your doctor, you will be given disability credit for each month you are disabled, as follows:

- For up to 4 months if the injury or sickness was incurred outside work
- For up to 6 months if the injury or sickness was incurred while working

Disability credit is provided as if you worked the Minimum Required Hours in a month and will continue your eligibility for the third month after the month for which the credit is given. However, eligibility for Life Insurance under Article XII and Accidental Death & Dismemberment benefits under Article XIII does not continue during periods of extended eligibility due to disability under this Article II, Section 8.

If you are working for an Employer who employs 50 or more employees when you become disabled, you may qualify under the federal Family Medical Leave Act (FMLA) for extended coverage during a period of FMLA leave from your Employer. FMLA leave is typically unpaid leave available for certain family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own serious illness. The Plan provides extended coverage during periods of FMLA leave certified by your Employer. If you go on an FMLA leave of absence, please contact the Administrative Office. You may contact your Employer or the Administrative Office for more information on FMLA.

COBRA continuation coverage is also available if you lose coverage due to a reduction in hours or for certain other qualifying events. However, you must pay for COBRA. For details regarding COBRA, see Article XIV, Section 1.

10. If You Should Die

If you should die, coverage for your Dependent(s) will continue to the end of the period for which you had earned eligibility. They may then be eligible for COBRA continuation coverage by making the appropriate payments. For details regarding COBRA, see Article XIV, Section 1.

11. If You Should Divorce (or Terminate Your Domestic Partnership)

If you divorce or end your domestic partnership, coverage for your Spouse/Domestic Partner and his or her child(ren) will end on the last day of the month in which the divorce (or dissolution of marriage) or termination of your domestic partnership occurs. Your Spouse and/or stepchildren may then be eligible for COBRA continuation coverage by making the appropriate payments, if your divorce is timely reported to the Fund. For details regarding COBRA, see Article XIV, Section 1.

You must timely notify the Fund of your divorce or termination of your domestic partnership. If you do not notify the Fund within 60 days of your divorce (dissolution of marriage) or end of your domestic partnership, your former Spouse/Domestic Partner and his/her child(ren) will not be eligible to elect COBRA coverage.

12. Non-Bargained Employees

Coverage under the Plan may be obtained for employees subject to a Participation Agreement but not covered by a Collective Bargaining Agreement, subject to the approval of the Trustees.

13. Rescission of Coverage

A rescission is a cancellation or discontinuance of Plan coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

The Plan will not retroactively cancel or terminate coverage (a rescission), except in the circumstances permitted by law, such as when contributions and self-payments are not timely paid, or, upon 30 days' advance written notice, in cases when an individual performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Retroactive termination of an ex-Spouse's coverage due to the failure to timely notify the Fund Office of a divorce or dissolution of marriage is not a "rescission of coverage."

The following examples constitute a material misrepresentation for which the Fund may rescind (retroactively cancel) coverage: enrolling someone as a Dependent who does not qualify as a Dependent or knowingly submitting a false claim or appeal for benefits.

If the Fund rescinds your Plan coverage, the result will be that you and your Dependents were never covered under the Plan, and you and your Dependents must repay the Fund the full amount it paid for all benefits (including premiums paid to an HMO or insurer) provided as a result of misrepresentation or fraud.

III. OUTLINE OF PLAN BENEFITS

1. Medical Benefits

Medical benefits are provided to all eligible and enrolled Employees and their Dependents. You and your Dependents must be enrolled in the same medical plan.

A. The Martin Luther King Community Healthcare Program

After your eligibility is established, you will be able to enroll yourself and your Dependents in the Martin Luther King Community Healthcare Program (the "MLK Program") if you live within 15 driving miles of the Martin Luther King, Jr. Community Hospital. If you live more than 15 driving miles from the Martin Luther King, Jr. Community Hospital, you will still be permitted to enroll in the MLK Program if you wish, as long as you live or work within 30 driving miles of the Martin Luther King, Jr. Community Hospital.

The MLK Program is described in Article IV of this SPD.

B. The Health Net of California, Inc. Plan

If you live more than 15 driving miles from the Martin Luther King, Jr. Community Hospital: After your eligibility is established, you will be able to enroll yourself and your Dependents in the Health Net of California Plan (sometimes called the "Health Net Plan" or the "Health Net HMO Plan") for medical benefits.

If you live within 15 driving miles of the Martin Luther King, Jr. Community Hospital: After you have been covered under the MLK Program for at least 12 consecutive months, you can switch to the Health Net HMO Plan during the next annual Open Enrollment period if you live or work within 30 miles of a Health Net contracted medical group or facility**.**

The Health Net Plan is briefly described in Article V of this SPD.

C. The Kaiser Permanente HMO Plan

After you have been covered under the MLK Program or the Health Net Plan for at least 12 consecutive months, you may be able to switch to the Kaiser Permanente HMO Plan (the "Kaiser HMO Plan") **during the next annual Open Enrollment period.** Not all Employees can switch to Kaiser. **In order to enroll in the Kaiser HMO Plan, you must satisfy the following requirements:**

- You must work for an Employer that contributes at least the minimum amount per hour required for coverage under the Fund's Kaiser HMO Plan;
- You must have been covered under the Fund's MLK Program or Health Net Plan for a minimum of 12 consecutive months after initially becoming eligible for Fund coverage; and
- You must live or work within 30 miles of a Kaiser Permanente medical group or facility.

In addition, some Participants (for example, participants in the Hotel Plan) have to pay a monthly employee contribution for coverage under the Kaiser HMO Plan.

Under certain limited circumstances, the Board of Trustees may authorize exceptions to the general rule described above.

The Kaiser HMO Plan is briefly described in Article VI of this SPD.

D. Making the Choice between Medical Plans

If you have a choice between medical plans, you should make your selection carefully because you will only be allowed to change your selection once per year, during Open Enrollment (see Article II, Section 6), unless you have a Special Enrollment opportunity (see Article II, Section 7). The Fund's three medical plans are different.

You should review the descriptions of these plans in Articles IV, V and VI of this SPD before making your decision. You can also compare the "Summary of Benefits and Coverage" for each plan, which can be obtained from the Administrative Office.

2. Prescription Drug Benefits

The Prescription Drug Program described in this SPD is provided by Express Scripts to all eligible Employees and Dependents. You have the same Express Scripts prescription drug benefits, regardless of the medical plan in which you are enrolled. You must use a pharmacy contracted with Express Scripts to fill your prescription. A list of Express Scripts network pharmacies will be provided to you upon request, without charge. The Prescription Drug Program provided by Express Scripts is described in Article VII of this SPD.

3. Dental Benefits

Dental benefits are provided to all eligible Employees and their Dependents, but you must enroll yourself and your Dependents in one of the Fund's insured dental plans or you will not have dental insurance.

A. The United Concordia Dental Care Plan

You can enroll yourself and your Dependents in the Dental Care Plan provided by United Concordia. You can always choose this dental plan, regardless of the medical plan in which you are enrolled. United Concordia's Dental Care Plan is briefly described in Article VIII of this SPD.

B. The Delta Dental PPO Plan

In order to enroll in the Delta Dental PPO Plan, you must work for an Employer that contributes at least the minimum amount per hour required for coverage under the Delta Dental PPO Plan. The Delta Dental PPO Plan is briefly described in Article IX of this SPD.

4. Vision Benefits

A materials allowance (for glasses or contacts) is available through the Vision Service Plan Benefit ("VSP Benefit").

For the HMO Plans (i.e., Kaiser and Health Net), eye exams are covered by your HMO, not through the VSP Benefit.

For the MLK Program, eye exams are covered through the VSP Benefit.

For more information on vision benefits and your cost sharing, see Article X of this SPD.

5. Member Assistance Program (MAP) Benefits

Member Assistance Program (MAP) benefits are provided by Beacon Health Options. The MAP is available to all eligible Employees and their Dependents, regardless of the medical plan in which you are enrolled. The MAP is briefly described in Article XI of this SPD.

6. Life Insurance Benefits

Once your eligibility is established, you will automatically be covered for Life Insurance benefits; even if you do not enroll for medical coverage. However, you must be eligible for benefits in accordance with Article II (i.e., based on Hours Worked) at the time of your death in order to qualify for Life Insurance benefits. Life Insurance benefits are provided directly by the Fund on a self-funded basis (i.e., not through an insurance company), regardless of the medical plan in which you are enrolled. These benefits are described in detail in Article XII of this SPD.

7. Accidental Death & Dismemberment Benefits

Once your eligibility is established, you will automatically be covered for Accidental Death & Dismemberment benefits, even if you do not enroll for medical coverage. However, you must be eligible for benefits in accordance with Article II (i.e., based on Hours Worked) at the time of accidental death or dismembering injury in order to qualify for these benefits. These benefits are described in detail in Article XIII of this SPD.

IV. THE MARTIN LUTHER KING COMMUNITY HEALTHCARE PROGRAM

(You Must Use Network Providers, Except for Emergency Services)

MLK Scheduling Line for Doctor Appointments
(Monday-Friday: 8:00 a.m. to 5:00 p.m.): (424) 529-6755

Claims Administrator (DBA) Customer Service
(8:00 a.m. to 5:00 p.m. Monday-Friday): (833) 961-3021 (TTY: (915) 221-8353)

Or visit http://www.MLKCHplan.com for Information About Network Providers

This Article describes the Martin Luther King Community Healthcare Program (the "MLK Program"). Except where the context indicates otherwise, references to "you" and "your" in this Article IV generally refer to any person eligible and enrolled for benefits under the MLK Program, either as an Employee or as the Dependent of an Employee. You may find the "MLK Program Definitions" section helpful in understanding some of the terms used throughout this Article IV.

The MLK Program is an exclusive provider organization healthcare plan that is self-funded directly by the Fund and administered by Design Benefits Administrators, Inc. ("DBA"). **Under the MLK Program, all of your healthcare, except Emergency Services must be provided by Network Providers or there is no coverage**. In addition, many services require Referral and Prior Authorization as outlined in Section 2.B. on page 18. The MLK Program does not provide coverage for outpatient prescription drugs. For information on prescription drug coverage, please see "The Prescription Drug Program Provided Through Express Scripts" under Article VII. of this SPD.)

1. MLK Program Service Area

Most medical care for the MLK Program is provided by the MLK Community Medical Group located in South Los Angeles. The service area for the MLK Program is 15 driving miles from the Martin Luther King, Jr. Community Hospital (the "MLK Hospital") in South Los Angeles. If you do not live within the MLK Program Service Area, you can still choose to enroll in the MLK Program if you live or work within 30 driving miles of the MLK Hospital.

2. How The MLK Program Works – An Overview

MLK Community Medical Group - If you are enrolled in the MLK Program your healthcare will generally be managed by your Primary Care Physician and will be provided by physicians and Healthcare Professionals within the MLK Community Medical Group. Most hospital services will be provided by the MLK Hospital.

You can make an appointment, including same day appointments, with your Primary Care Physician or with another available Primary Care Physician within the MLK Community Medical Group without having a Referral or Prior Authorization. Most other services, including specialist care, require a Referral and Prior Authorization. Referrals and Prior Authorizations within the MLK Community Medical Group will be handled automatically by your Primary Care Physician.

The MLK Community Medical Group offers primary and specialty care for adults and children. Services currently available through MLK Community Medical Group Providers include but are not limited to: Primary care for adults and children, specialty care such as: addiction treatment, diabetes management, heart disease, infectious disease, lung disease, and mental/behavioral health.

Extended Network - The MLK Program also maintains a broader network of Physicians and Providers (including urgent care centers, Outpatient Surgical Centers, and Hospitals) to provide services that are not available through the MLK Community Medical Group. This broader network is called the "Extended Network." **With very few exceptions, you must have a referral to a Provider in the Extended Network, and you must have Prior Authorization for services from the Provider**. Extended Network Providers will generally obtain Referrals and Prior Authorizations for you.

Tertiary Network - Finally, the MLK Program maintains a third network, provided by First Health (referred to as the "Tertiary Network" or "First Health Network") that will be accessed only for Emergency Services or to provide treatment for rare or unusual conditions that are not available from the MLK Community Medical Group or the Extended Network. With the exception of Emergency Services, you must have a Referral to a Provider in the First Health Network, and you must have Prior Authorization for the services, otherwise the treatment that you receive will not be covered.

A. How To Select A Primary Care Physician

You and each of your enrolled Dependents must select a Primary Care Physician ("PCP") within the MLK Community Medical Group. If you do not select a PCP for yourself or for any enrolled Dependent, one will be assigned to you. Generally, you select a PCP when you first enroll in the MLK Program. You can change your PCP by calling DBA at (833) 961-3021. Different family members can select different PCPs.

Currently, there are three medical office locations where you and your enrolled Dependents can obtain your primary care. Different PCPs staff the different medical offices, though some PCPs work at more than one location. A current list of PCPs, including the medical offices where the PCPs are located, is available through the website located at www.MLKCHplan.com or by calling DBA at (833) 961-3021.

The MLK Community Medical Group has one scheduling phone number for all of the medical office locations; they can be reached at (424) 529-6755. Scheduling hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday.

Here are the medical office locations for primary and specialty care within the MLK Community Medical Group:

East Compton Clinic
135 E. Compton Blvd.
Compton, CA 90222

Rosecrans Clinic
2251 W. Rosecrans Ave., Suite 18
Compton, CA 90222

Wilmington Clinic
12021 Wilmington Ave., Building 11, Suite 1000
Los Angeles, CA 90059

B. Referrals and Prior Authorization

If you need care that your PCP cannot provide, and you need to see a Specialist or other Provider for that care, you will need to have a Referral. MLK Community Medical Group Providers and Extended Network Providers will obtain Referrals for you.

In addition to needing a Referral, you will need Prior Authorization for most services beyond what is provided in a typical office visit with your Physician. MLK Community Medical Group providers, Extended Network Providers, and Tertiary Network Providers will usually obtain Prior Authorization for you. However, you should always be sure to verify that Prior Authorization has been obtained.

Please note, for services requiring Prior Authorization and/or Referral – if you do not obtain Prior Authorization and/or Referral when necessary, the services are not covered.

Services for Which Referral and Prior Authorization Are Not Required

You do not need a Referral or Prior Authorization to see your Primary Care Physician in the MLK Community Medical Group (or another Primary Care Physician in the MLK Community Medical Group).

You do not need a Referral or Prior Authorization to go to an Urgent Care Center in the Extended Network.

In addition, you do not need a Referral or Prior Authorization to obtain access to obstetrical or gynecological care from a Provider in the MLK Community Medical Group or Extended Network who specializes in obstetrics or gynecology. In addition, you do not need a Referral or Prior Authorization for an office visit for diagnosis or treatment of a Mental Disorder and/or Substance Use Disorder from a Provider in the MLK Community Medical Group or Extended Network. The Provider, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals.

Finally, Referrals and Prior Authorization are never required for Emergency Services or for childbirth. In serious Emergency situations, call "911" or go to the nearest Hospital.

More information is available in Section 9 of this Article IV ("Utilization Management and Prior Authorization Requirements").

C. Claims Administration

When you receive services, you will generally be asked to pay any Copayments up front. If you have Coinsurance, the Provider will bill you for your Coinsurance after you receive services if you have not paid it already. Network Providers in the MLK Community Medical Group, the Extended Network and the First Health Network will submit claims for services directly to the MLK Program's Claims Administrator. The Claims Administrator will adjudicate claims and issue payment to the Provider. You will be sent an Explanation of Benefits ("EOB") that shows how the claim was adjudicated, including the contracted price for the services, the portion that the MLK Program has paid, and the portion, if any, that is your responsibility.

The MLK Program's Claims Administrator is Design Benefits Administrators, Inc. ("DBA"). Call DBA Customer Service at (833) 961-3021 if you need further information or have questions regarding your coverage or claims administration, including questions about specific exclusions and limitations in benefits.

For details on claims procedures, refer to Section 11, Claims and Appeals Procedures and External Review Process, which can be found beginning on page 47.

3. Covered Expenses

Expenses that are covered in whole or in part by the MLK Program are called Covered Expenses. Covered Expenses are limited to expenses for medical services and supplies that are:

1. **Medically Necessary**, but only to the extent that the expense does not exceed the Allowed Amount (or if the Provider is a Network Provider, the amount that the Provider has agreed by contract to accept for the service or supply); and

2. **Not excluded from coverage** (see the Exclusions and Limitations section of this Article IV. for more information); and

3. **For the diagnosis or treatment of an Illness or Injury** (except where preventive services are payable or as specifically covered under the MLK Program); and

4. **Not in excess of a benefit maximum** as described in the Schedule of Benefits; and

5. **Provided or ordered by a Physician or other Healthcare Professional**; and

6. **Incurred while the Participant is eligible for coverage and enrolled in the MLK Program.**

4. Medical Expenses that are Not Covered

The MLK Program will not pay or reimburse you for any expenses that are not Covered Expenses. This means you are responsible for the full cost of services and supplies that are determined to be not Medically Necessary, or are in excess of a benefit maximum, and for services that are not covered by the MLK Program or were provided when you were not eligible for coverage. For Out-of-Network Providers, you are also responsible for any Balance Billing for charges above the Allowed Amount.

5. Your Costs

a. **Your Out-of-Pocket Costs**

You must pay for a certain portion of the cost of covered health care services under the MLK Program, including copayments or your coinsurance percentage that is not paid by the MLK Program. These are called your "out-of-pocket costs."

- ***Copayment:*** A Copayment (sometimes called a "Copay") is a fixed amount (e.g., $5) that you must pay for a Covered Expense.

- ***Coinsurance:*** Coinsurance is the percentage of costs of a Covered Expense you pay (e.g., 20%).

- ***Out-of-Pocket Costs:*** Out-of-pocket costs are your expenses for health care that are not paid or reimbursed by the MLK Program. Out-of-pocket costs include Copayments and Coinsurance for Covered Expenses, plus all costs for services that are not covered by the MLK Program, including Balance Billing for Out-of-Network Providers.

Copayments and Coinsurance percentages are shown below in the "Schedule of Medical Benefits."

b. If You Use an Out-of-Network Provider

The MLK Program's payment amounts for services provided by Out-of-Network Providers (e.g., Emergency Room, Ambulance) is based on an Allowed Amount. The MLK Program's Allowed Amount for a given service may be less than what the Out-of-Network Provider charges for that service. When that happens, you are responsible for your Copay or Coinsurance, plus the difference in cost between the Provider's billed charge and the MLK Program's Allowed Amount. This is called Balance Billing.

Example: For example, if an Out-of-Network Emergency Room charges $2,400 for a service and the MLK Program's Allowed Amount is $1,800, you will be responsible for your $150 Copayment, and the Provider may also balance bill you for the remaining $600.

c. Out-of-Pocket Maximum and Other Limits

The MLK Program limits the out-of-pocket costs you must pay toward Covered Expenses in a calendar year (both individually and for your Family Unit), as shown in the "Schedule of Medical Benefits." This is called your "out-of-pocket maximum." After you have paid this amount for Covered Expenses, the MLK Program pays 100% of the cost of Covered Expenses for the rest of the calendar year. Please note, however, that not all expenses are eligible to accumulate toward your out-of-pocket maximum, nor are all expenses paid at 100% in the event you reach your out-of-pocket maximum. The following expenses do not count towards your out-of-pocket maximum, and are not paid at 100% in the event you reach your out-of-pocket maximum in a calendar year:

- Anything you spend for services that the MLK Program does not cover, including Out-of-Network services that are not covered;
- Charges that exceed a benefit maximum;
- Costs, including copayments, for Prescription Drugs through Express Scripts (see Article VII); and
- Balance Billing charges.

If you have any questions about whether an expense is a Covered Expense, or whether it is eligible for accumulation toward your out-of-pocket maximum, please contact the Claims Administrator for assistance.

6. Schedule of Medical Benefits

A schedule of the Plan's medical benefits appears on the following pages in chart format. The chart outlines specific covered services and the amount you will pay for the services. It also contains information about benefit limits, exclusions, and other important information. This schedule of benefits is not all-inclusive, however. Important additional information is contained in the sections that follow the chart.

In addition, the MLK Program has other requirements and provisions that may affect benefits. It is strongly recommended that you read this entire Article IV. to ensure a complete understanding of the MLK Program provisions. You may also contact DBA (the Claims Administrator for the MLK Program) for assistance.

The following is the Schedule of Medical Benefits. Please note, **for services requiring Prior Authorization and/or Referral – if you do not obtain Prior Authorization and/or Referral when necessary, the services are not covered.**

SCHEDULE OF MEDICAL BENEFITS – MLK PROGRAM			
SERVICES THAT ARE COVERED	**What you will pay IN NETWORK**	**What you will pay OUT OF NETWORK**	**LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION**
Referrals and Prior Authorizations are required for all services unless stated otherwise. If you do not obtain Prior Authorization and/or Referral when required, the services are not covered.			
Out-of-Pocket Maximum - Medical	$1,500 individual $3,000 family	No Maximum	
Out-of-Pocket Maximum – Prescription Drug – Network Pharmacies	$750 individual $1,500 family *No maximum for certain specialty drugs, see Article VII*	No Maximum	This is not provided through the MLK Program; please see "The Prescription Drug Program Provided Through Express Scripts" under Article VII. of this SPD. The Prescription Drug Out-of-Pocket Maximum does not apply to certain specialty drugs.
Deductible	None	None	
PREVENTIVE CARE The MLK Program covers preventive care services in accordance with the requirements of the Affordable Care Act.	$0 copay	Not covered	Listing of covered preventive services is available at www.healthcare.gov/preventive-care-benefits. Referral and Prior Authorization not required when obtained through your Primary Care Provider.
Includes periodic Health Evaluations such as Preventive Vision and Hearing Screening, Blood Pressure, Diabetes and Cholesterol Tests	$0 copay	Not covered	
EMERGENCY & URGENTLY NEEDED CARE			
Emergency Room	$150 per visit	$150 per visit	Must meet definition of Emergency. No Referral or Prior Authorization required. Out of Network coverage subject to Balance Billing.
Urgent Care Center	$10 copay	Not covered	You do not need a Referral or Prior Authorization to go to an Urgent Care Center in the Extended Network.
Ambulance – Ground	$50 per trip	$50 per trip	Out-of-Network coverage must meet definition of Emergency. Out of Network coverage subject to Balance Billing. Referral and Prior Authorization not required in cases of Emergency.
Air Ambulance	$50 per trip	$50 per trip	Coverage available only for Emergency Medical Condition. Referral and Prior Authorization not required.

SCHEDULE OF MEDICAL BENEFITS – MLK PROGRAM			
SERVICES THAT ARE COVERED	**What you will pay IN NETWORK**	**What you will pay OUT OF NETWORK**	**LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION**
Referrals and Prior Authorizations are required for all services unless stated otherwise. If you do not obtain Prior Authorization and/or Referral when required, the services are not covered.			
HOSPITALIZATION & INPATIENT SERVICES			
Inpatient Room & Board (including Intensive care)	$0 copay	Not covered	Limited to $100,000 per hospitalization.
Outpatient Facility (includes hospital-based Outpatient Surgical Center)	$0 copay	Not covered	
Skilled Nursing Facility	$0 copay	Not covered	Limited to 100 days per calendar year.
Hospice Care	$0 copay	Not covered	For Patients with one year or less to live.
PHYSICIAN, OFFICE, HOME AND TELEHEALTH			
Physician Visits & Professional Visits			
Primary Care Office Visit (Includes Physician Assistant and Nurse Practitioner)	$5 copay	Not covered	Referral and Prior Authorization not required.
Specialist Consultation or Care (with Referral)	$5 copay	Not covered	Referral and Prior Authorization not required for gynecology services when obtained from a Provider in the MLK Community Medical Group or Extended Network.
Surgeon, Assistant Surgeon and Anesthetist	$0 copay	Not covered	
Home Health Care	$0 copay	Not covered	
Telehealth Services	$5 copay	Not covered	Telehealth services are covered only if provided by a MLK Provider. Referral and Prior Authorization is not required for telehealth services associated with a Primary Care Office Visit.
OUTPATIENT FACILITY SERVICES			
Outpatient Surgical Center	$0 copay	Not covered	
Outpatient Facility Services (other than surgery)	$0 copay	Not covered	
DIAGNOSTIC IMAGING			
Diagnostic Imaging other than Outpatient X-Ray (CAT Scans, PET Scan, MRI)	$0 copay	Not covered	
Outpatient laboratory & X-ray	$0 copay	Not covered	

SCHEDULE OF MEDICAL BENEFITS – MLK PROGRAM			
SERVICES THAT ARE COVERED	**What you will pay IN NETWORK**	**What you will pay OUT OF NETWORK**	**LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION**
Referrals and Prior Authorizations are required for all services unless stated otherwise. If you do not obtain Prior Authorization and/or Referral when required, the services are not covered.			
OTHER PROFESSIONAL SERVICES			
Allergy Testing	$0 copay	Not covered	
Acupuncture	$5 copay	Not covered	
Maternity Care	$0 copay	Not covered	Referral and Prior Authorization not required when obtained from a Provider in the MLK Community Medical Group or Extended Network.
Infertility Diagnosis	$0 copay	Not covered	Diagnosis services covered; infertility treatment not covered. Coverage for infertility diagnosis limited to initial diagnosis only.
Infertility Treatment	Not covered	Not covered	
Chiropractic Services and Supplies	$5 copay	Not covered	
Physical, Occupational, Speech Therapy	$5 copay	Not covered	
Pulmonary and Cardiac Rehabilitation Therapy	$5 copay	Not covered	
Chemotherapy and Radiation Therapy	$0 copay	Not covered	
Renal Dialysis	$0 copay	Not covered	
Organ Tissue or Stem Cell Transplant	$0 copay	Not covered	
MEDICAL SUPPLIES AND EQUIPMENT			
Durable Medical Equipment (DME)	20% coinsurance	Not covered	Covered charges include the rental of durable medical equipment, or, at the Claim Administrator's discretion, the equipment may be purchased. Benefits for rental will not exceed the usual, customary, and reasonable fee for purchase.
Diabetic Equipment	20% coinsurance	Not covered	
Orthotics/Orthopedic Appliances	$0 copay	Not covered	
Prostheses	$0 copay	Not covered	

SCHEDULE OF MEDICAL BENEFITS – MLK PROGRAM			
SERVICES THAT ARE COVERED	**What you will pay IN NETWORK**	**What you will pay OUT OF NETWORK**	**LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION**
Referrals and Prior Authorizations are required for all services unless stated otherwise. If you do not obtain Prior Authorization and/or Referral when required, the services are not covered.			
Breast Pump and Supplies Needed to Operate the Pump	$0 copay	Not covered	Coverage (rental or purchase, at the Claim Administrator's discretion) for one standard breast pump for the duration of breastfeeding (plus supplies to operate the breast pump). Benefit limit of $250 for purchase of a maternal breast pump.
Blood and Blood Products	$0 copay	Not covered	
Hearing Aids	Not covered	Not covered	
Outpatient Medical & Surgical Supplies	$0 copay	Not covered	
MENTAL HEALTH AND SUBSTANCE USE DISORDER			
Inpatient Services	$0 copay	Not covered	
Outpatient office visit/ Professional Consultation	$5 copay	Not covered	Referral and Prior Authorization not required when obtained from a Provider in the MLK Community Medical Group or Extended Network.
Other Outpatient Services	$5 copay	Not covered	

7. Covered Medical Services
(All Services Require Referral and Prior Authorization Unless Otherwise Stated)

The MLK Program covers In-Network medical services (and Out-of-Network Emergency Services), provided that the services are obtained while you are eligible for coverage and enrolled in the MLK Program, and that the services are Covered Expenses, as defined on page 41. All such services must be Medically Necessary and will be covered in accordance with the Schedule of Medical Benefits, subject to all limitations, exclusions, benefit maximums, Prior Authorization requirements and other provisions of the MLK Program.

This Section provides more detailed information about the types of medical services that are covered by the MLK Program, but is not an exhaustive list of all services covered by the MLK Program.

You should refer to the Utilization Management and Prior Authorization Requirements section for important information concerning the MLK Program's Utilization Management program and for requirements to obtain prior authorization for most medical services.

1. Hospital Inpatient Services

a. Inpatient Care
For medical or surgical care of an Illness or Injury, the MLK Program covers semi-private room and board, operating and delivery rooms, drugs, medicines, oxygen, blood and blood products given to the patient during the hospital stay, X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), and necessary ancillary services, including cardiac care units and intensive care units, when appropriate for the covered person's illness or injury.

b. Physicians' In-Hospital Services

Professional services rendered by a Physician while the Participant is hospitalized or confined to an inpatient facility.

c. **Pre-Admission Testing** for an approved Hospital admission when the testing is not duplicated upon admission. Early admission for testing is generally not covered (see Exclusions and Limitations section for more details).

d. Maternity Care (Prior Authorization is not required)
Hospital services for maternity are covered the same as Inpatient care and are provided in compliance with the Newborns' and Mothers' Health Protection Act of 1996 (described in Article XV., Section 6. of this SPD, on page 99).

Newborn Care (Prior Authorization is not required)

e. Services for newborn children include nursery and neo-natal intensive care room and board, necessary ancillary expenses, and routine newborn care during the period of hospital confinement and outpatient services from birth to the 30th day, including circumcision.

f. **Breast Reconstruction.**
Coverage of mastectomy-related breast reconstructive surgery will be subject to the same Copayment and Coinsurance provisions that currently apply to mastectomy coverage and will be provided in consultation with you and your attending physician, in accordance with the Women's Health and Cancer Rights Acts of 1998 (described in Article XV., Section 5. of this SPD, on page 99).

2. Skilled Nursing (or Extended Care) Facilities
Semi-private room and board accommodations and necessary ancillary charges, limited to 100 days per calendar year.

3. Rehabilitation services for certain illnesses or injuries based on an approved treatment plan, often rendered at a Rehabilitation Facility.

4. Mental Disorder and Substance Use Disorders (including detoxification) - Inpatient
Prior Authorization is required for all non-emergency inpatient care. The MLK Program covers semi-private room and board and necessary ancillary services. Treatment must be rendered in a network facility.

5. Surgical Inpatient and Outpatient Services

a. Anesthesia Services
Administration of anesthesia by a licensed provider, including a Certified Registered Nurse Anesthetist (CRNA).

b. Surgeon and Surgical Assistants
Services by a licensed Physician or licensed surgical physician's assistant to the operating surgeon for surgical procedures when warranted. Services include pre- and post-operative care.

c. Obstetrical Services
Rendered by the Physician, including prenatal and postnatal care. Benefits are determined based on the MLK Program provisions in effect on the date services are rendered.

6. Professional Interpretation Services for Diagnostic Tests (Inpatient and Outpatient) by a licensed radiologist or pathologist for covered diagnostic tests required for the diagnosis or treatment of an Illness or Injury.

7. Outpatient Services for services provided in an outpatient department of a Hospital or other facility

a. Hospital Emergency Room Services for Emergency Medical Condition (Prior Authorization is not required)
Coverage for Emergency Services, including Physician's charges, charges for radiology and pathology, and facility charges.

b. Outpatient Diagnostic Examinations Services such as X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG).

c. Outpatient Surgical/Ambulatory Surgery Center
Charges by a hospital or ambulatory surgical center for services and supplies required for a covered outpatient surgical procedure.

d. **Cardiac or Pulmonary Rehabilitation** program approved by the attending physician.

e. **Chemotherapy Services** for administration of treatment, including required drugs and supplies.

f. **Kidney Dialysis** treatment, including necessary drugs and supplies.

g. **Intravenous Therapy**
Administration of intravenous therapy, including necessary drugs and supplies.

h. **Occupational Therapy**
To restore a Participant to health or to social or economic independence if performed by a licensed occupational therapist after evaluation and development of a proposed rehabilitation plan. Occupational therapy must be ordered by the attending physician as part of a treatment plan that is appropriate for the Participant's Illness or Injury.

i. **Physical Therapy**
For restoration of function and prevention of disability following Illness, Injury, or loss of a body part. Such services are not covered when medical documentation does not support Medical Necessity because of the Participant's inability to progress toward the treatment plan goals or when a Participant has already met the treatment goals.

j. **Speech Therapy**
The evaluation and treatment of voice, speech, language, swallowing, cognitive, or hearing disorders. You are required to use services reasonably available through the community before benefits become available under the MLK Program.

k. **Radiation Therapy**
Treatment by X-ray, radium, external radiation, or radioactive isotopes, including materials.

8. **Physician Outpatient Services**
Benefits are provided for the following services rendered in a physician's office, including services by a physician's assistant ("P.A."), Registered Nurse (R.N., L.V.N., or L.P.N.), nurse practitioner or other licensed Healthcare Professional rendered under the supervision of the Physician and billed by the Physician.

a. **Office Visits**
Services provided in a physician's office that are required for the diagnosis or treatment of an Illness or Injury, including telehealth visits provided by a MLK Primary Care Provider.

b. **Allergy Care**
Allergy care, including testing, injections, serums, and extracts that are required for the treatment of an illness or injury. Immunizations and other injections for foreign travel or occupational purposes are not covered.

c. **Diagnostic X-ray and Laboratory Services**
As required for the diagnosis or treatment of an Illness or Injury.

d. Chiropractic Care Services

Spinal manipulation supported by physical or radiological documentation of subluxation of the spine, other related therapy treatments, and X-rays. Chiropractic care must be rendered for the active treatment of an Illness or Injury and must be related to a chiropractic visit. Such services are not covered when medical documentation does not support the Medical Necessity because of the patient's inability to progress toward the treatment plan goals or when a patient has already met the treatment goals. Maintenance care is not covered.

9. Mental Disorder and Substance Use Disorder Services – Outpatient and Partial Hospitalization

For Outpatient Mental Disorder conditions, benefits are provided for care by a licensed psychologist, psychiatrist, therapist, and/or social worker (provided the social worker services are under the direct supervision of a Physician). Outpatient services include psychological and neuropsychological testing and other outpatient treatment. For the treatment of Substance Use Disorder, covered services include outpatient detoxification, intensive outpatient care programs, and day treatment.

10. Preventive Care Services (Prior Authorization generally not required)

The MLK Program covers certain preventive care services at no cost to you when such services are provided by an MLK Provider or referred and authorized by an MLK Provider.

The preventive care services are designed to comply with the Affordable Care Act (ACA) and are based on the following: (i) the A & B recommendations of the U.S. Preventive Services Task Force (USPSTF), and (ii) Guidelines from the Health Resources and Services Administration (HRSA), the American Academy of Pediatrics/Bright Futures, and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

Preventive care services must be received from an MLK Provider. **Preventive care services received from a non-MLK providers will not be covered,** unless there is no MLK Provider who can provide the preventive care service, or if it would be medically inappropriate for you to obtain the service from an MLK Provider (e.g., a Participant needs a preventive service in a setting not available from an MLK Provider). In either of these situations, you must obtain a Referral from your MLK Provider in order to receive the preventive care service from an Extended Network Provider.

Preventive care services include, but are not limited to:

- Periodic health evaluations
- Blood pressure, diabetes, and cholesterol tests
- Cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use
- Routine immunizations against diseases such as measles, Herpes Zoster (shingles), Hepatitis A and B, Tetanus, Diphtheria, Pertussis, and meningitis.
- Flu and pneumonia vaccines

- COVID-19 vaccines
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits, including prenatal and postnatal office visits.
- Well-woman visits
- Family Planning - Contraceptives (including Voluntary Sterilization)

  Female: **The MLK Program** covers counseling and planning for contraception, fitting examinations for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an intrauterine device (IUD). Sterilization of females and women's contraception methods and counseling are covered as Preventive Care Services. Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable and implantable contraceptives. Contraceptive drugs are not covered under the MLK Program but are covered under the Prescription Drug Program Provided Through Express Scripts (see Article VII).

  The Prescription Drug Program covers contraceptives available from the retail pharmacy with a prescription, including birth control pills. Such contraceptives include vaginal, oral, transdermal and emergency contraceptives (FDA-approved drugs taken after intercourse to prevent pregnancy). See Article VII., The Prescription Drug Program Provided Through Express Scripts.

  Coverage includes voluntary female and male sterilization.

The list of covered preventive care services is reviewed and updated on an annual basis. Talk with your Primary Care Physician about the preventive care services that are appropriate for you. For information about covered preventive care medications (including certain vitamins) and products, please refer to Article VII., "The Prescription Drug Program Provided Through Express Scripts."

Please note:

- If you receive other covered services and supplies in addition to preventive care services during the same office visit, you may be required to pay the applicable Copayment or Coinsurance for those other services.
- If a preventive service is billed separately from an office visit, then the office visit is subject to normal plan benefits (including copayment and/or coinsurance).
- If a preventive service is not billed separately from an office visit, and the office visit is primarily for the purpose of providing preventive services, then the office visit is payable at 100% (no copayment and/or coinsurance).
- If a preventive service is not billed separately from an office visit, and the main purpose of the office visit is not for the purpose of providing preventive services, then the office visit is subject to normal plan benefits (including copayment and/or coinsurance).

- Federal guidelines and the MLK Program set standards (such as age, treatment, setting, and frequency) for the coverage of specific preventive care services, which must be satisfied in order to obtain coverage.

11. Second Surgical Opinions

To determine Medical Necessity for a recommended surgical procedure. See page 39 ("Second Surgical Opinion" in Section 9.B. for more details).

12. Ambulance Service (Prior Authorization not required for Emergency Medical Condition)

Local professional ground ambulance service is covered for Medically Necessary transportation to or from the Hospital only when the Participant is confined as a bed patient, or for an accident, Emergency, or acute illness.

Air ambulance services available only for Emergency Medical Condition and when Medically Necessary.

13. Approved Clinical Trials

Routine patient costs for an Approved Clinical Trial for the prevention, detection, or treatment of cancer or other life-threatening disease or condition that is one of the following: (1) a federally funded or approved trial; (2) a clinical trial conducted under an FDA investigational new drug application; or (3) a drug trial that is exempt from the requirement of an FDA investigational new drug application.

14. Durable Medical Equipment (DME)

Covered charges include the rental of durable medical equipment, or at the Claim Administrator's discretion, the equipment may be purchased. Benefits for rental will not exceed the usual, customary, and reasonable fee for purchase.

DME includes Oxygen, dressings, splints, casts, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home or that have a value in the absence of an illness or injury.

Prosthetic devices and supplies, including initial purchase price, fitting, adjustment and repairs. Replacements of prosthetic devices are not covered unless due to a significant change in the covered Participant's physical structure and the current device cannot be made serviceable.

DME includes Orthotics containing a shoe permanently attached to a brace, but only for patients with foot disfigurements.

DME includes Breast Pumps - The Participant will be reimbursed up to $250.00 towards the purchase of a maternal breast pump.

15. Cochlear implants

16. Home Health Care

Home health services include services and supplies required for treatment of an Illness or Injury in a Participant's home when rendered by a licensed and accredited Home Health Care Agency. These services must be provided according to a formal, written home health care treatment plan (covering length, type and frequency of visits). Home Health Care includes:

Skilled nursing care provided by a licensed vocational nurse or registered nurse and /or licensed physical, occupational, speech therapist or respiratory therapist who does not ordinarily live in your home and who is not a member of your immediate family.

- Services are part-time and intermittent in nature and a visit last up to 4 hours in every 24 hours.

- Services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility or outpatient services provided outside of the Participant's home.

The total benefits paid for home health care on a weekly basis may not exceed the amount that would have been paid if the Participant had been confined in a hospital, skilled nursing facility, or other facility.

17. Hospice Services

Subject to Prior Authorization, covered services include hospice services for a terminally ill (less than one year to live) Participant when provided by a Hospice Care Agency. The services must be provided through a formal, written Hospice care treatment program and certified by the attending Physician as Medically Necessary.

Hospice services may be provided for a Participant on an inpatient basis in a hospice facility by a Hospice Care Agency or in the Participant's home.

Hospice benefits include Physician services, palliative care (pain control and symptom relief), counseling, medications, other necessary services and supplies, homemaker services and respite services.

- Room and board for confinement in a licensed, accredited Hospice Care Agency.

- Services and supplies furnished by the Hospice Care Agency while the patient is confined.

- Part-time nursing care by or under the supervision of a registered nurse.

- Nutrition services and/or special meals.

- Respite services.

- Services by a licensed social worker or a licensed counselor.

- Bereavement counseling by a licensed social worker or a licensed counselor for the Participant and/or covered family members of the Participant.

The attending Physician must certify that the covered Participant is expected to live for fewer than twelve months in order to qualify for this benefit.

18. Blood transfusions and blood products, to the extent not replaced up to a maximum of $120 per unit.

19. Developmental disorders, including autism and Applied Behavioral Analysis (ABA). Subject to Prior Authorization.

20. **Oral surgical procedures**, including:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongues, roof, and floor of the mouth.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. Emergency repair due to injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands, or ducts.

21. **Treatment of Temporomandibular Joint Dysfunction**
Custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders) are covered if they are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, dental implants or other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered.

22. **Chelation therapy** for a diagnosis of lead poisoning, or a diagnosis of anemia for a child.

23. **Transplants/Replacement of Organs/Tissues and Related Services**
Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered if the transplant recipient is a Participant in the MLK Program and Prior Authorization is obtained.

Medically Necessary services, in connection with an organ, tissue or stem cell transplant are covered as follows:

- For the enrolled Participant who receives the transplant; and
- For the donor (whether or not an enrolled Participant), if the recipient is a Participant.
- Benefits for the donor are reduced by any amounts paid or payable by the donor's own coverage. Only Medically Necessary services related to the organ donation are covered.
- The preparation, acquisition (including donor search), transportation, and storage of human organs, bone marrow, or human tissue, is covered to a maximum of $20,000.
- Travel expenses and hotel accommodations associated with organ, tissue and stem cell transplants are not covered.

8. Exclusions and Limitations

In addition to any other exclusions or limitations stated elsewhere in this SPD, the following services are excluded from coverage, and the MLK Program does not pay benefits for the following:

- Any expense that is not a Covered Expense.
- Services or supplies that are not Medically Necessary, unless specifically covered under the Plan, such as preventive care benefits.
- Services or supplies from Out-of-Network Providers, except for Emergency Services.
- Expenses incurred by an organ donor, unless the recipient of the organ is a Participant.
- Paramedic services when the patient is not transported to a Hospital, unless the Participant is deceased upon arrival of the paramedics or prior to or during transport to the Hospital.
- Services or supplies that are provided to a Participant for which there is no charge (or the provider customarily makes no direct charge) or for which the Participant is not legally obligated to pay, including charges that are submitted to the MLK Program equal to any amount for which Provider has discounted fees or has "written off" amounts due.
- **Maintenance chiropractic care.**
- **Contraceptive drugs.** Contraceptive drugs are not covered under the MLK Program. However, coverage is available under the Prescription Drug Program Provided Through Express Scripts (see Article VII.).
- **Experimental or Investigational.** Experimental or Investigational services, supplies, procedures, treatments, therapies, or drugs, and any complications arising therefrom, except as required under the federal Affordable Care Act for clinical trials.
- **Aversion Therapy.** Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.
- **Biofeedback.** Benefits are not provided for biofeedback.
- **Prescription drugs.** Prescription drugs, unless administered while a bed patient in a hospital or dispensed in a physician's office or unless specifically provided herein. (Coverage for prescription drugs is available under the Prescription Drug Program Provided Through Express Scripts (see Article VII.)).
- **Civil insurrection, riot, War.** Expenses resulting from injuries incurred or exacerbated while participating in a civil insurrection, riot, or illegal act, and any condition, injury, or illness resulting from war or an act of war, whether declared or undeclared, or any act of aggression or invasion, and any complication therefrom.
- **Complications.** Complications arising from services or treatment that are not covered under the MLK Program, except when complications exceed routine follow up care. This exclusion does not apply to complications of pregnancy.

- **Corrective appliances.** Including, but not limited to, corrective shoes (unless connected permanently to a brace), trusses, corsets, and other support devices.

- **Cosmetic.** Cosmetic surgery, treatment, or procedures, including aesthetic services, and complications arising therefrom. This exclusion does not apply to (1) procedures required to repair damage caused by an accidental bodily injury (restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury is not considered cosmetic), (2) procedures approved as Medically Necessary for a covered Illness, or (3) breast reconstruction following a mastectomy.

- **Counseling.** Counseling for social maladjustment, pastoral issues, financial issues, behavioral issues, or lack of discipline or other antisocial action is covered only when provided as treatment for a Mental Disorder or Substance Use Disorder. The Fund's Member Assistance Program (MAP) described in Article XI. provides counseling for many of these issues.

- **Court-ordered services.** Services or supplies that are ordered by a court, unless determined to be Medically Necessary and a Covered Expense.

- **Custodial care and homemaker services.** Custodial care, regardless of the type of facility and/or Provider, and homemaker services, unless specifically covered under Hospice Services.

- **Dental care.** Dental care including, but not limited to, dental treatment on or to teeth or gums, including tumors (except as specifically covered under the MLK Program), dental prescriptions (such as Peridex or fluoride), and hospital admissions for dental care (unless Medically Necessary because of a concomitant condition). See Article VIII. and IX. for information on dental benefits provided through United Concordia and Delta Dental.

- **Eating disorders.** Treatment of eating disorders and services and products relating thereto.

- **Morbid Obesity.** Services and products related to treatment of Morbid Obesity, including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, medications, food or food supplements, exercise programs, club or gym memberships, exercise or other equipment, and other services and supplies that are primarily intended to control weight or treat obesity or for the purpose of weight reduction, regardless of the existence of co-morbid conditions. This exclusion does not apply to preventive care benefits (such as diet counseling and obesity screening) under the MLK Program.

- **Early Admission for Testing.** Early admission to the Hospital is generally not covered unless admission is within 24 hours of surgery.

- **Educational services and vocational training.** Services and products related to education or vocational training, including, but not limited to: computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, auditory or speech aids/synthesizers, auxiliary aids, communication boards, listening systems, devices/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading, or self-esteem, etc., special education and associated costs in connection with tactile systems like Braille or sign language education for a patient or family members, and vocational testing, evaluation, and counseling. This exclusion does not apply to Applied Behavioral Analysis (ABA Therapy) when determined to be Medically Necessary for the treatment of autism or other developmental disorders, nor does it apply

to educational services rendered for diabetic counseling, peritoneal dialysis, or other services covered under the MLK Program as preventive care services.

- **Eyeglasses, contact lenses, vision materials.** Vision materials and fittings, including lenses, frames, contact lenses, and fittings of glasses and contact lenses. Refer to Article X. for information about vision benefits available under VSP.

- Vision exams. Vision exams are not covered under the MLK Program, but may be obtained through the VSP Benefit. For more information on vision benefits, see Article X of this SPD.

- **Food supplements and vitamins,** including, but not limited to, Food or nutritional supplements or augmentation in any form (unless Medically Necessary to sustain life in a critically ill person) and vitamins and/or minerals taken orally. Certain vitamins are covered as Preventive Care under the Fund's Prescription Drug Program (e.g., prenatal vitamins). See Article VII.

- **Foot care services (routine).** Routine foot care, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care performed in the absence of localized illness, injury, or symptoms involving the foot.

- **Forms.** The completion of medical reports, claim forms, or itemized billings.

- **Government services.** Unless payment is legally required, services or supplies (1) furnished by or for any government, (2) provided under any governmental program or law under which the patient is or could be covered, or (3) furnished by a hospital or facility run by the United States government or any authorized agency, or at the expense of such government or agency. This exclusion does not apply to any program for civilian employees of a government.

- **Growth Hormone Therapy.**

- **Hearing aids.** Hearing aids or devices, or the examination for their prescription and fitting.

- **Illegal Act.** Injury or sickness incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions), regardless of whether the medical condition was diagnosed before the Injury**.**

- **Immediate relative.** Services provided by an immediate relative (that is, the Participant's spouse or domestic partner, child, brother, sister, or parent, whether by birth, adoption, or marriage) or by an individual residing in the Participant's home, except for Covered Expenses that constitute out-of-pocket expenses to such Providers.

- **Impotence.** Impotence treatment and medications or drugs pertaining to impotence.

- **Infertility treatment**, including, but not limited to, artificial conception processes (such as in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and embryo transplants), fertility drugs, artificial insemination, reversal of a voluntary sterilization procedure, surrogate mothers/pregnancy, donor eggs, or sperm banks.

- **Late claims.** Any claim for benefits filed after the applicable deadline for filing the claim under the MLK Program.

- **Massage Therapy.** Massage therapy is not covered, unless applied in conjunction with other active physical therapy modalities for a specific covered Illness or Injury and approved as Medically Necessary by DBA.

- **Mental Health and Substance Use.** Services for the diagnosis and treatment of mental health and substance use conditions that do not meet the MLK Program's definition of Mental Disorder or Substance Use Disorder.

- **No Injury or Illness:** Expenses incurred for any condition where there exists no Injury or Illness, except that this exclusion does not apply to benefits specifically covered under the MLK Program, such as preventive care services.

- **Noncovered Treatments.** The following types of treatment are only covered when Medically Necessary or when provided in connection with covered treatment for a Mental Disorder or Substance Use Disorder:

  - Treatment for co-dependency.

  - Treatment for psychological stress.

  - Treatment of marital or family dysfunction.

  - Treatment of neurocognitive disorders which include delirium, major and mild neurocognitive disorders.

- **Non-medical items.** Including, but limited to, personal hygiene or convenience items and personal items provided in a hospital.

- **Non-prescription (over-the-counter).** Medicine, equipment, and supplies that can be purchased over-the-counter or without a prescription from a licensed Physician, unless otherwise a Covered Expense and the items have been approved through Prior Authorization.

- **Nonstandard Therapies.** Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, aromatherapy, bioenergetic therapy, sleep therapy, hypnotherapy, crystal healing therapy, rolfing, psychodrama, herbal medicine, homeopathy, transcendental meditation and yoga, hypnosis, naturopathy, and megavitamin therapy.

- **Not eligible or enrolled.** Expenses incurred while the patient was not eligible or not enrolled for coverage.

- **Orthognathic Surgery** (jaw realignment surgery) to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.

- **Outside of the U.S.A.** Any care, services, drugs, treatment or supplies incurred outside of the United States of America.

- **Patient Comfort/Convenience.** Services and supplies that are related to the modification of homes, vehicles, or personal property, including, but not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment, and cervical pillows. This exclusion also applies personal or comfort items and to any services or supplies that are provided during a course of treatment for an Illness or Injury that are primarily for the personal comfort or convenience of the patient and not Medically Necessary (such as ambulance services for transportation primarily to suit the Participant's or physician's convenience).

- **Physical Therapy** services are not covered when medical documentation does not support Medical Necessity because of the Participant's inability to progress toward the treatment plan goals or when a Participant has already met the treatment goals.

- **Preadmission Testing** for an approved Hospital admission is covered only if the testing is not duplicated upon admission.

- **Prohibited by law.** Services or supplies for which the MLK Program is prohibited by law or regulation from providing benefits.

- **Third party responsibility.** Services, supplies, care, and/or treatment of an injury or sickness for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party, including medical malpractice. See the "Subrogation, Third-Party Recovery and Reimbursement" section of this Article IV. below for more information.

- **Surrogate pregnancies.** Surrogate pregnancies and all related charges, both when the surrogacy is for a Participant and when a Participant is the surrogate.

- **Tax and shipping.** Taxes and shipping charges levied on Medically Necessary items and services. This exclusion does not apply to surcharges required by law to be paid by the MLK Program in applicable states.

- **Temporomandibular Joint Dysfunction.** Custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders) are covered if they are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, dental implants or other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered.

- **Travel**, even if prescribed by a physician.

- **Travel immunizations.** Immunizations or injections for foreign travel or occupational purposes are not covered.

- **Weekend Admissions.** Weekend admission (Friday, Saturday or Sunday) to a hospital, unless due to an Emergency or if surgery is performed within 24 hours of admission.

- **Without approval.** Services or supplies not prescribed, recommended, or approved by a Physician or other Health Professional acting within the scope of his or her license.

- **Work-related illness or injury.** Any condition, illness, or injury arising out of or in the course of employment or self-employment or for which the covered person is entitled to benefits under any workers' compensation or similar law.

- **Gene Therapy Medications**.

9. Utilization Management and Prior Authorization Requirements

The MLK Program's Utilization Management Program ("UM Program") is designed to reduce the cost and risk of unnecessary medical services, and to identify cost-effective and low-risk services available for the treatment of your medical condition. The UM Program includes Prior Authorization, Concurrent Review, Second Surgical Opinion, and Case Management.

A. Prior Authorization

Prior Authorization (which is sometimes referred to as Pre-Certification) is the process of advance review that the MLK Program uses to make sure that certain health care services, supplies, and/or medications recommended by your Healthcare Professional are Medically Necessary and appropriate and meet or exceed accepted standards of care.

So long as your Provider is a MLK Provider, or a Provider in the Extended Network, your Provider will, typically, contact DBA (the Claims Administrator) to obtain Prior Authorization on your behalf. However, it is your responsibility to make sure that you receive Prior Authorization for any health care services subject to the MLK Program's Prior Authorization requirements. If you have any questions about obtaining a Prior Authorization, please contact DBA at (833) 961-3021.

Under the MLK Program, Prior Authorization is required for most care other than office visits with your Primary Care Physician (PCP) or another PCP in the MLK Community Medical Group. For example, Prior Authorization is required for most non-emergency specialty care, x-rays and labs, and elective inpatient and outpatient surgeries.

Under the MLK Program, as specified in the Schedule of Medical Benefits starting on page 21, Referrals and Prior Authorization are required for all services unless stated otherwise. Article IV, Section 9.A. (on page 38) and this subsection A. each contain a description of services that do not require Prior Authorization (See "Services for Which Referral and Prior Authorization Are Not Required," immediately below). All other services and supplies require Prior Authorization.

If Prior Authorization is not obtained when required, the services will not be covered.

Obtaining Prior Authorization does not mean that benefits are guaranteed or payable or that the particular service or supply is a benefit covered under the MLK Program. It means only that the service or supply has been approved as Medically Necessary and appropriate. Eligibility for and payment of benefits are subject to the terms and conditions of the MLK Program and the Fund.

If you fail to obtain Prior Authorization and/or Referral when it is required, you will not have coverage for the service or supply, even if it is Medically Necessary.

Prior authorization is never required for Emergency Services (including childbirth). Do not delay seeking medical care for a Participant who has a serious condition that may jeopardize their life or health.

Services for Which Referral and Prior Authorization Are Not Required

You do not need a referral or Prior Authorization to see your Primary Care Physician in the MLK Community Medical Group (or another Primary Care Physician in the MLK Community Medical Group).

You do not need a Referral or Prior Authorization to go to an Urgent Care Center in the Extended Network.

In addition, you do not need a Referral or Prior Authorization to obtain access to obstetrical or gynecological care from a Provider in the MLK Community Medical Group or Extended Network who specializes in obstetrics or gynecology, nor do you need a Referral or Prior Authorization for an office visit for Mental Disorder or Substance Use Disorder from a Provider in the MLK Community Medical Group or Extended Network. The Provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Finally, Referrals and Prior Authorization are never required for Emergency Services or for childbirth. In serious emergency situations, call "911" or go to the nearest Hospital.

Concurrent Review.

If you are admitted to a Hospital or other inpatient facility, the MLK Program will monitor your stay and conduct an on-going review of the course of your treatment.

If your continued stay or services are found to not be Medically Necessary, and it is found that care could be safely and effectively delivered in another environment (such as at home or in another type of care facility), you and your Physician will be notified. This does not mean that you have to leave the Hospital or stop receiving the services at issue. However, if you choose to stay or continue services that are no longer Medically Necessary, expenses incurred after notification to you will be your responsibility.

The MLK Program will not conduct a concurrent review if the MLK Program is the secondary payor of benefits (see Coordination of Benefits on page 62).

B. Second Surgical Opinion.

If your Provider recommends non-Emergency surgery or elective surgery as part of your medical treatment, the MLK Program will, subject to the terms and conditions hereafter stated, provide coverage for all charges incurred in connection with obtaining a second surgical opinion when requested by the Participant, provided the second surgical opinion is requested and obtained through DBA.

In order to evaluate the proposed treatment, the MLK Program will require detailed medical information from your physician, including: the identity of the patient (including date of birth and sex); the diagnosis code (ICD-9); the procedure code (CPT); and the amount of the proposed charge.

This information should be submitted to:

Design Benefits Administrators, Inc.
P.O. Box 11669
San Bernardino, CA 92423

Once the necessary information is received, DBA will obtain the second surgical opinion. The Physician rendering the second opinion will not be affiliated with the Physician who recommended the surgical procedure. A third opinion will be covered if the two opinions differ, and the third opinion will be performed by a Physician who is not affiliated with the Physicians who have previously rendered opinions.

You will receive a written response with the Plan's determination, which you may furnish to your Physician if you so desire.

Do not delay seeking medical care for any Participant who has a serious condition that may jeopardize his life or health in order to seek a Second Surgical Opinion. Second surgical opinions are not recommended where a person's life or health is in jeopardy.

C. Case Management Program

In certain circumstances, especially in the case of a very serious illness or injury, the MLK Program may make available its Case Management Program services to the covered Participant. This is strictly a voluntary program; Participants are not obligated to participate and benefits will not be adversely affected.

The Case Management Program is administered by DBA. Case managers are medical professionals who will work with your attending Physician to identify alternative courses of treatment to assist you in receiving treatment that is evidence-based and cost effective. They can be of invaluable assistance in locating resources to assist in the maintenance or recovery of health.

If you are selected as a candidate for case management, you will be contacted by a case manager who will then work with you and your Physician throughout the course of treatment. If you have any questions about the Case Management Program, please feel free to contact Design Benefits Administrators at (831) 961-3021.

10. MLK Program Definitions

When the following terms are used in this Article IV. of this booklet, they have the meanings described below:

Accident. A sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

Allowed Amount. The amount that the MLK Program allows for covered services or supplies provided by an out-of-network Provider (e.g., out-of-network Emergency Services). The Allowed Amount is the lesser of (1) the Provider's actual billed charge or (2) the dollar amount that will be allowed for the Medically Necessary service or supply. You are responsible for your cost sharing portion (Coinsurance, Copayment) of the Allowed Amount, as well as any charges that exceed the Allowed Amount. Any charge above the Allowed Amount does not count toward your out-of-pocket maximum (nor does it count towards the Prescription Drug out-of-Pocket Maximum under the Prescription Drug Program).

Ambulatory Surgical Center or Ambulatory Surgery Center. See "Outpatient Surgical Center" below.

Balance Bill or Balance Billing. When a Provider bills you for the difference between what the Provider actually charged (the billed amount) and the MLK Program's Allowed Amount. For example, if the Provider's charge is $200 and the Allowed Amount is $110, the Provider may bill you for the remaining $90. This could happen when you use an out-of-network Provider for Emergency Services. A Network Provider may not Balance Bill you for covered services.

Calendar Year. The twelve-month period beginning at 12:00 a.m. on January 1 and ending at 11:59 p.m. on December 31.

Claims Administrator means Design Benefits Administrators (DBA), with whom the Board of Trustees has contracted to handle claims administration and the day-to-day operations of the MLK Program.

Coinsurance. Your share of the cost of a covered health service, calculated as a percentage (for example, 20%) of the Covered Expense.

Complication(s) of Pregnancy. Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Conditions include, but are not limited to, acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia, and a terminated ectopic pregnancy. Morning sickness and a non-emergency caesarean section are not complications of pregnancy, nor is false labor, occasional spotting, or prescribed rest during the period of pregnancy.

Cosmetic or Cosmetic Surgery means any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

Copayment or Copay. A fixed amount you pay for a covered service, usually when you receive the service. The Copayments for covered services are shown in the Schedule of Benefits.

Covered Expenses. As described on page 19 of this SPD, Covered Expenses are those expenses that are covered in whole or in part by the MLK Program and are limited to expenses for medical services and supplies that are:

1. **Medically Necessary**, but only to the extent that the expense does not exceed the Allowed Amount (or if the Provider is a Network Provider, the amount that the Provider has agreed by contract to accept for the service or supply); and

2. **Not excluded from coverage** (see the Exclusions and Limitations section of this Article IV for more information); and

3. **For the diagnosis or treatment of an Illness or Injury** (except where preventive services are payable or as specifically covered under the MLK Program); and

4. **Not in excess of a benefit maximum** as described in the Schedule of Benefits; and

5. **Provided or ordered by a Physician or other Healthcare Professional**; and

6. **Incurred while the Participant is eligible for coverage and enrolled in the MLK Program.**

Custodial Care. Care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered.

DBA. See "Design Benefit Administrators" below.

Design Benefits Administrators ("DBA") means Design Benefits Administrators, Inc. who serves as the Claims Administrator (including Prior Authorization reviews) and provides day-to-day administrative functions for the MLK Program. DBA can also answer your questions about coverage and benefits under the MLK Program. You can reach DBA by calling them at (833) 961-3021.

Detoxification. A set of interventions aimed at managing acute intoxication and withdrawal which involves the clearing of toxins from the body of the patient who is acutely intoxicated and/or dependent on substances of abuse, while minimizing the physical harm caused by the abuse of substances.

Diagnostic. An examination, service, test, or procedure performed for specified symptoms to detect or to monitor an Illness or Injury and that is ordered by a Physician or other Healthcare Professional.

Durable Medical Equipment. Equipment which:

- Is primarily and customarily used to serve a medical purpose (i.e., its reason for existing is to fulfill a basic medical need, as opposed to satisfying personal preferences regarding style and range of capabilities, and it is not useful to anyone in the absence of Illness or Injury);
- Can withstand repeated use (i.e., it is not disposable or non-durable); and
- Is appropriate for use in the home.

Emergency. A situation where Medically Necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions. Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the MLK Program, that an Emergency did exist.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. Active labor is considered an Emergency Medical Condition. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) there is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Participant or unborn child.

Emergency Services. With respect to an Emergency Medical Condition, a medical screening examination within the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition along with additional medical examination and treatment to stabilize the patient. The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility (or, with respect to an Emergency Medical Condition involving a pregnant woman who is having contractions, to deliver a newborn child, including the placenta).

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational. Any service or supply, including any medical treatment or procedure, equipment, drug, or device, which:

A. Is not normally and regularly used or prescribed by the medical community of Southern California for the reason that it remains under clinical or laboratory investigation or has not been exposed to clinical or laboratory investigation; or

B. Is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, or efficacy (including its efficacy as compared with the standard means of treatment or diagnosis); or

C. Has been shown, by Reliable Evidence, that the consensus among experts is that further studies or clinical trials are necessary to determine the maximum tolerated dose, toxicity, safety, or efficacy (including its efficacy as compared with the standard means of treatment or diagnosis). "Reliable Evidence" means published reports and articles in authoritative medical and scientific literature, the written protocol(s) used by the treating facility or by another facility studying substantially the same service or supply (including the drug, device, treatment or procedure), or the written informed consent used by the treating facility or by another facility studying substantially the same service or supply.

DBA and the Trustees may rely on the advice of medical consultants in determining whether a service or supply is "Experimental" or "Investigational" under this definition.

Facility. An institution, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, and includes facilities such as a Hospital, Ambulatory Surgical Center/Outpatient Surgical Center, psychiatric Hospital, community mental health center, residential treatment facility, Substance Use Treatment Center or Facility, or any other such facility approved by the Trustees.

Family unit. The Employee and his or her covered Dependents.

Health Care Professional. An individual who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or authority. For example, this may include a Physician, physician assistant, a nurse practitioner, an anesthesiologist, a stand-by physician or a midwife acting within the scope of his/her license and/or authority.

Home Health Care Agency. An agency or organization that provides a program of home health care and which meets one of the following three tests:

- Is approved by Medicare and/or accredited by The Joint Commission (TJC);
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, meets all the following requirements:
  - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or registered nurse (R.N.) to the home;
  - It has a full-time administrator;
  - It is run according to rules established by a group of Providers including Physicians and R.N.s;
  - It maintains written clinical records of services provided to all patients;
  - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
  - Its employees are bonded and it maintains malpractice insurance.

Hospice Care Agency. A facility or program that provides hospice services (as described in Section 7, Covered Medical Services) in a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice Care Agency and its employees must be licensed and operated according to applicable state and local laws and certified by Medicare for the primary purpose of providing hospice services. It must meet all of the following requirements:

- Provides 24 hour a day, seven days a week service, supervised by a qualified practitioner;
- Has a full-time coordinator and a licensed social service coordinator;
- Keeps written records of services provided to each patient; and
- Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients.

Hospital. A legally operated facility licensed by the state where it is located as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Illness. A bodily condition, sickness, or disease not resulting from trauma, as diagnosed by a Physician and as compared to the person's previous condition. Any congenital abnormality of a newborn child and Pregnancy are considered "Illnesses" under the MLK Program.

Incurred. The date on which the service is rendered or the supply is obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step or phase are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Injury. Physical damage to the body, caused by an external force.

Inpatient. Any person who, while confined to a Hospital or other Facility, is assigned to a bed in any department other than its outpatient department and for whom a charge for room and board is made by the Hospital or other Facility.

Investigational. See "Experimental or Investigational" above.

Mastectomy. The surgical removal of all or part of a breast.

Medically Necessary. Services or supplies that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice within the organized medical community;
- Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the symptoms, diagnosis or direct care and treatment of the patient's Injury, disease, or Illness;
- Provided for the diagnosis or direct care and treatment of the medical condition, Injury, or Illness;
- Not primarily for the convenience of the patient, Physician, or other health care Provider;

- Not Experimental, educational, or unproven (Investigational); and

- The most appropriate supply or level of service which can safely be provided.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed, or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under the MLK Program because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

For purposes of the definition of Medically Necessary, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, National Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

DBA and the Trustees may rely on the advice of medical consultants in determining whether a service or supply is Medically Necessary under this definition.

Medicare. The program of health care for the aged and disabled established by Title XVIII of the U.S. Social Security Act of 1965, as amended.

Mental Disorder. Any illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

MLK Community Medical Group. The Martin Luther King, Jr. Community Medical Group, located in South Los Angeles. The providers and facilities within the MLK Community Medical Group comprise the primary Network of Providers and Facilities under the MLK Program. The MLK Community Medical Group consists of: (1) the facilities associated with the MLK Community Medical Group, including the three outpatient medical offices (in Compton, Rosecrans, and Wilmington) and the MLK Hospital, and (2) the Physicians and other Health Care Professionals who staff those facilities.

MLK Hospital. The Martin Luther King, Jr. Community Hospital, located in South Los Angeles.

MLK Program means the Martin Luther King Community Healthcare Program described in Article IV of this SPD/Plan Document.

MLK Provider. A Provider who is part of the MLK Community Medical Group, such as Physicians (including your Primary Care Physician) and other Health Care Professionals affiliated with the MLK Community Medical Group. You do not need a Referral or Prior Authorization to make an appointment with your Primary Care Physician or another MLK Provider who provides primary care.

Morbid Obesity. A diagnosed condition in which a person's body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility.

Network. The Facilities, Providers, and suppliers that the Fund has contracted to provide health care services under the MLK Program. The MLK Program has three provider networks: the MLK Community Medical Group, the Extended Network, and the First Health Network (also called the Tertiary Network). The MLK Program does not cover services from Out-of-Network Providers, except for Emergency Services.

Network Provider. A Provider who the Fund has contracted to provide health care services to Participants in the MLK Program. (Network Providers are in the MLK Community Medical Group, the Extended Network, or the First Health Network. Providers in the MLK Community Medical Group and Extended Network have a direct contract with the Fund to provide services to Participants in the MLK Program).

Out-Of-Network Provider. A Provider who does not have a contract with the Fund to provide health care services to Participants in the MLK Program, i.e., who does not meet the definition of a Network Provider.

Outpatient Surgical Center (sometimes referred to as Ambulatory Surgical Center). A facility other than a medical office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Physician. A person legally licensed as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), or Psychologist (Ph.D.) under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license and is not the patient.

Pre-admission Testing. Diagnostic services done before a scheduled Hospital Inpatient admission, provided that:

- The tests are required by the Hospital and approved by the Physician;
- The tests are performed on an outpatient basis prior to Hospital admission;
- The tests are not duplicated on admission to the Hospital; and
- The tests are performed at the Hospital where the confinement is scheduled, or at a qualified facility approved by the Hospital to perform the tests.

Primary Care Physician ("PCP"). A Physician who coordinates and controls the delivery of covered services and supplies to the Participant. Primary Care Physicians generally include, but are not limited to, general and family practitioners, internists, pediatricians, and obstetricians/gynecologists.

Prior Authorization (sometimes called Preauthorization or Pre-Certification). A decision by DBA before services or supplies are provided that the service (including treatment, admission, or length of stay in a healthcare Facility) or supply is Medically Necessary and appropriate. Obtaining Prior Authorization does not mean that benefits are guaranteed or payable or that the particular service or supply is a benefit covered under the MLK Program. It means only that the service or supply has been approved as Medically Necessary and appropriate. For more information, see page 37.

Provider. A Physician, Health Care Professional, or a health care Facility (e.g., Hospital, Ambulatory Surgical Center/Outpatient Surgical Center, Hospice, Skilled Nursing Facility) that is licensed, certified, or accredited in accordance with the requirements of applicable law.

Referral. A written or electronic order from an MLK Provider (usually your Primary Care Physician) for you to see a specialist or get specialty care within the MLK Community Medical Group or to see a Provider in the Extended Network or the First Health Network. If you do not get a Referral first, the MLK Program will not pay for the services. For a full description of the Providers or services for which a referral is required, see the Schedule of Medical Benefits.

Rehabilitation Facility. A Facility which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state, and local laws;
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or
- It is approved for its stated purpose by Medicare.

Skilled Nursing Facility. A Skilled Nursing Facility is an institution operated pursuant to law which meets each of the following requirements:

(a) It is regularly engaged in providing skilled nursing care for sick and injured persons under twenty-four (24) hour a day supervision of a physician or registered nurse;

(b) It maintains a daily medical record for each patient;

(c) It complies with all licensing and other legal requirements;

(d) It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for alcoholics, a hotel or a similar institution.

Substance Use Disorder ("SUD"). Any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

11. Claims and Appeals Procedures and External Review Process

These claims and appeals procedures and external review process apply to requests for medical benefits provided through the MLK Program (referred to as "Health Claims"). The term "Health Claim" is defined below.

The claims administrator for the MLK Program is Design Benefits Administrators, Inc. ("DBA"). All Health Claims, appeals of denied Health Claims, and requests for external review must be filed with DBA. Requests for voluntary second-level review should be filed with the Administrative Office.

Contact DBA at (833) 961-3021 if you have any questions regarding these claims and appeals procedures. You may also write to DBA at the following address: Design Benefits Administrators P.O. Box 11669, San Bernardino, CA 92423.

For purposes of these claims and appeals procedures and external review process, the term "you" or "your" refers to a Claimant or a Claimant's Authorized Representative, unless otherwise indicated. The terms "Claimant" and "Authorized Representative" are defined below.

A. Definitions

Claimant: A Participant (i.e., a covered Employee or a covered Dependent) in the MLK Program who submits a Health Claim.

Health Claim: A request for medical benefits under the MLK Program submitted by the Claimant or the Claimant's Authorized Representative to DBA in accordance with these claims and appeals procedures and external review process.

A Health Claim is not: (1) a mere request for information about benefits under the MLK Program; (2) a dispute concerning eligibility for benefits under the MLK Program, including COBRA coverage, that is unrelated to a specific Health Claim; or (3) a request for prior approval (or referral) where prior approval (or referral) is not required by the MLK Program.

There are four types of Health Claims, as follows: Post-Service Claims, Pre-Service Claims, Urgently Needed Care Claims, and Concurrent Care Claims. The rules for submitting, processing, and appealing a Health Claim depend on the type of Health Claim filed.

- **Post-Service Claim:** A Health Claim for which approval is not required prior to obtaining services and that involves only the payment or reimbursement of the cost of the care that has already been provided. A paper claim and an electronic bill, submitted for payment after services have been provided, as well as claims for services received in an Emergency, are examples of Post-Service Claims.

- **Pre-Service Claim:** A Health Claim that is a request for benefits, where the MLK Program conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care (these include claims for which a referral or prior authorization is required).

- **Urgently Needed Care Claim:** A Pre-Service Claim where the usual time for processing either (1) could seriously jeopardize the patient's life, health, or ability to regain maximum function or (2) would subject the patient to severe pain that cannot be adequately managed without the care that is the subject of the Pre-Service Claim. The patient's attending provider will determine whether a Pre-Service Claim is an Urgently Needed Care Claim, and DBA will defer to such determination.

- **Concurrent Care Claim:** If DBA (the claims administrator) has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, a decision to reduce or terminate the ongoing course of treatment before the end of the approved treatment or period of time is considered the denial of a Health Claim. You will be notified of such denial in advance of the reduction or termination and be given the opportunity to appeal and obtain a determination on appeal before treatment is reduced or terminated. A Concurrent Care Claim also refers to a type of Health Claim that is a request by you to extend a pre-approved course of treatment. The services that will receive concurrent care review are listed in the "Utilization Management & Prior Authorization Requirements" section of this Article IV.

B. Use of an Authorized Representative

For purposes of this subsection B., the term "you" or "your" refers to a Claimant only.

You may designate an "Authorized Representative" to act on your behalf in filing a Health Claim, appealing a denied Health Claim, or requesting a voluntary second-level review or external review.

Contact DBA to request a form that you can use to designate an Authorized Representative. Your completed form must be submitted to DBA. *In the case of Urgently Needed Care Claims, however, a Health Care Professional with knowledge of your medical condition will be permitted to act as your Authorized Representative without your written designation*.

Once you designate an Authorized Representative, all future communications from the Plan will be with your Authorized Representative, rather than to you, unless you direct DBA, in writing, to the contrary.

An Authorized Representative designation will be valid until it is revoked or otherwise expires. You may revoke a designation at any time by submitting a written request to revoke the designation to DBA.

Note: An assignment of benefits by a Participant to a Provider will not constitute an appointment of that Provider as the Participant's Authorized Representative.

C. General Rules

Requirement to Exhaust the MLK Program's Internal Claims and Appeals Procedures. You must exhaust the MLK Program's internal claims and appeals procedures before filing a civil action under ERISA Section 502(a) against the Fund or the Board of Trustees. This means that before you may take legal action, you must follow all of the applicable procedures for filing an internal claim and an appeal with DBA, as described in these claims and appeals procedures.

Failure to Follow Procedures. You may take legal action without first exhausting the MLK Program's internal claims and appeals procedures if DBA fails to comply with these internal claims and appeals procedures. This rule, however, does not apply if DBA's failure is minor and (1) does not prejudice you, (2) is not attributable to good cause or matters beyond DBA's control, (3) occurs in the context of a good faith exchange of information between you and DBA, and (4) is not reflective of a pattern or practice of noncompliance. If this type of minor violation occurs, you may request a written explanation of the violation from DBA, and DBA will respond to your request within ten (10) days, with a specific description of the violation and an explanation as to why the violation should not cause the internal claims procedures to be deemed exhausted.

Limitation on When a Lawsuit May Be Filed. You may not commence a lawsuit or other legal action to obtain medical benefits under the MLK Program until after you have exhausted these internal claims and appeals procedures for every issue relevant to a Health Claim. However, you are not required to exhaust the MLK's Plan's voluntary second-level review process or the external review process before seeking a judicial remedy.

No lawsuit may be filed (started) more than 3 years after the end of the year in which services were provided. However, should you submit your dispute to voluntary second-level review and/or external review, this 3-year period will be tolled (i.e., suspended) while such review is pending.

D. Filing A Health Claim

For purposes of this subsection D., the term "you" or "your" refers to a Claimant only.

All Health Claims must be submitted to DBA by mail at Design Benefit Administrators, P.O. Box 11669, San Bernardino, CA 92423, by email to uniteherememberappeal@dbatpa.com, or by fax at (650) 562-8621.

MLK Community Medical Group Providers, Extended Network Providers, and First Health Network Providers will generally submit Health Claims for you. Out-of-Network Providers may also submit Health Claims on your behalf. Health Claims submitted by your Provider will be processed as if they were filed by you. If you need to file a Health Claim yourself, please call DBA to request a claim form.

Health Claims must be filed within one year after the date of service. Health Claims filed after this deadline will be denied. If a MLK Community Medical Group Provider, Extended Network Provider, or First Health Network Provider does not file a Health Claim on time, the Provider can bill you only for the copayment or coinsurance you would have paid if the Provider had filed on time.

A Health Claim is considered filed on the date it is received by DBA (or on the date postmarked, if mailed to DBA through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

E. Processing A Health Claim

Time Period for Processing a Health Claim. Health Claims will be processed within the following timeframes:

- **Post-Service Claims.** A Post-Service Claim will be processed within 30 days after it is received by DBA. This period may be extended by up to an additional 15 days if necessary due to matters beyond DBA's control, or longer if you are asked to submit information necessary to process your Post-Service Claim. You will be notified of any extension before it is taken, the reason for the extension, and the date a decision is expected. If asked to submit information necessary to decide a Post-Service Claim, you will be given at least 45 days to respond, and the time for the decision will be suspended from the date of the extension notice to the earlier of the date you respond or the due date set by DBA. You may voluntarily agree to extend the time for processing your Post-Service Claim.

- **Pre-Service Claims.** A Pre-Service Claim will be processed within 15 days after it is received by DBA. DBA may extend this period for up to an additional 15 days if necessary due to matters beyond its control, or longer if you are asked to submit information necessary to process your Pre-Service Claim. You will be notified of any extension before it is taken, the reason for the extension, and the date a decision is expected. If asked to submit information necessary to decide a Pre-Service Claim, you will be given at least 45 days to respond, and the time for DBA's decision will be suspended from the date of the extension notice to the earlier of the date you respond or the due date set by DBA. You may voluntarily agree to extend the time for processing your Pre-Service Claim.

- **Urgently Needed Care Claims.** An Urgently Needed Care Claim will be processed within a reasonable time, but not later than 72 hours after it is received by DBA. Notice of the decision on an Urgently Needed Care Claim may be provided orally, followed by a written notice within three (3) days. If DBA does not receive sufficient information to decide an Urgently Needed Care Claim, it will notify you or the patient's physician of such failure as soon as possible, but not later than 24 hours after receipt of the insufficient information. You will be afforded a reasonable amount of time, but not less than 48 hours, to provide the specified information. After receipt of the specified information, DBA will provide its decision as soon as possible, but in no case later than 48 hours after the earlier of: (1) its receipt of the specified information, or (2) the end of the period afforded you to provide the additional information.

- **Concurrent Care Claims.** If DBA has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, a reduction or termination of the course of treatment before the end of such period or number of treatments (other than by amendment or plan termination) is a Health Claim denial. DBA will notify you of such denial in advance of the reduction or termination and allow you to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

  If you request that a course of treatment be extended beyond the period of time or number of treatments initially approved and the request is an Urgently Needed Care Claim, the request will be decided as soon as possible, and you will be notified of the decision not later than 24 hours after receipt of the request, but only if your request was made at least 24 hours before the expiration of the approved period of time or number of treatments. Otherwise, the decision will be made as soon as possible, but not later than 72 hours after your request is made.

Failure to Properly File a Pre-Service or Urgently Needed Care Claim. If a communication from you is received by DBA that fails to follow the MLK Program's procedures for filing Pre-Service Claims or Urgently Needed Care Claims, but names the patient, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, you will be notified of the proper procedures to follow. This notice will be provided within five (5) days after receipt of the communication, or within 24 hours for an Urgently Needed Care Claim. This notice may be oral, unless you request written notice.

Contents of Initial Denial Notice. If your Health Claim is denied, in whole or in part, you will receive a written denial notice (usually an Explanation of Benefits or "EOB") that contains the following:

- Identifies the Health Claim involved and includes the date of service, the Health Care Provider, and the Health Claim amount (if applicable).

- States the specific reason(s) for the denial, the denial code (and its corresponding meaning), and a description of the Plan's standard(s), if any, that was used in denying the Health Claim.

- Refers to the specific Plan provision(s) on which the denial is based.

- States that you are entitled to receive, upon request, free access to and copies of documents relevant to your Health Claim, including the applicable diagnosis and treatment codes (and their meanings).

- Describes any additional material or information necessary for you to perfect your Health Claim and explains why such material or information is necessary.

- Describes the MLK Program's internal appeal procedures, including the time limits applicable to such procedures and information on how to initiate an appeal, as well as the availability of voluntary second-level review (for Post-Service Claims only) and external review, along with the applicable time limits.

- *For denials of Urgently Needed Care Claims only:* Describes the expedited review process applicable to Urgently Needed Care Claims.

- Includes a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following the denial of your Health Claim on appeal.

- States, if applicable, that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the Health Claim and that a copy of such rule, guideline, protocol, or other criterion will be provided to you, free of charge and upon request.

- States, if applicable, that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request, if the denial is based on a medical necessity or Experimental treatment or similar exclusion or limit.

F. Filing an Appeal of a Denied Health Claim

If your Health Claim is denied, in whole or in part, you may submit a written request to DBA asking for a review of the denial (this is called an "appeal"). You may submit your appeal by mail to Design Benefits Administrators, P.O. Box 11669, San Bernardino, CA 92423, by email to uniteherememberappeal@dbatpa.com, or by fax at (650) 562-8621. *An appeal of an Urgently Needed Care Claim may be submitted orally by calling DBA at (833) 961-3021*.

Your appeal must be filed with DBA within 180 days after you receive an EOB or other adverse benefit determination. An appeal is considered **filed** on the date it is received by DBA (or on the date postmarked, if mailed to DBA through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

Your appeal must be in writing and include the following information: the Employee's name, member ID, mailing address, and telephone number; if the patient is not the Employee, the patient's name, member ID, mailing address, and telephone number; the basis of your appeal, including a clear and concise statement of why you disagree with the handling of the Health Claim, as well as all facts and theories supporting the approval of your Health Claim; and any supporting documents, records, and other information. *An appeal of an Urgently Needed Care Claim, however, need not be written and may be submitted orally*.

G. Processing an Appeal

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Health Claim.

You will also be provided, automatically and free of charge: (1) any new or additional evidence considered, relied upon, or generated in connection with your Health Claim; and (2) any new or additional rationale for a denial at the internal appeals stage. This information will be provided to you as soon as possible, sufficiently before the decision on appeal is made, so that you will have a reasonable opportunity to respond before a final decision on appeal is rendered. If DBA receives new or additional evidence or rationale so late in the claim filing or claim appeal process that you would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as you have had such an opportunity.

You may submit written comments, documents, records, evidence, testimony, and other information relating to your Health Claim, which will be considered on appeal regardless of whether such information was submitted or considered in the initial review. *If you are appealing an Urgently Needed Care Claim, however, you may submit any information in support of your appeal orally, by facsimile, or by other available expeditious method.*

Your appeal will receive a full and fair review by DBA, and the party deciding the appeal will not be the same individual who denied the Health Claim, nor the subordinate of such individual. DBA will make an independent determination and will not afford deference to the initial review. You have no right to appear personally.

If a denial was based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, DBA will consult with a Health Care Professional who has experience in the field of medicine involved in your Health Claim. This Health Care Professional will not be the individual who was consulted in connection with the initial Health Claim denial, nor the subordinate of any such individual.

If you request, DBA will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of your Health Claim, even if the advice was not relied upon in denying the Health Claim.

Time Period for Processing an Appeal. Appeals will be processed within the following timeframes:

- **Post-Service Claims.** You will be provided with a written notice of the decision within 60 days after the appeal is filed.

- **Pre-Service Claims.** You will be provided with a written notice of the decision within 30 days after the appeal is filed.

- **Urgently Needed Care Claims.** You will be provided with a notice of the decision as soon as possible, but not later than 72 hours after the appeal is filed. The notice of the decision may be provided orally, by facsimile, or by other similarly expeditious method, followed by a written denial notice within three (3) days.

- **Concurrent Care Claims.** If your request to extend a concurrent care course of treatment is denied, you will be provided with a notice of the decision as soon as possible, but not later than 72 hours after the appeal is filed. Notwithstanding the previous sentence, your request to extend a course of treatment that does not involve urgent care will be decided in the normally applicable determination period, as it is not a Concurrent Care Claim.

Contents of Appeal Denial Notice. If your Health Claim is denied on appeal, in whole or in part, you will receive a written denial notice that contains the following:

- Information sufficient to identify the Health Claim involved, including the date of service, the Health Care Provider, and the Health Claim amount (if applicable).

- A discussion of the specific reason(s) for the denial of the Health Claim on appeal, the denial code (and its corresponding meaning), and a description of the Plan's standard(s), if any, that was used in denying the Health Claim on appeal.

- The specific Plan provision(s) on which the denial on appeal 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 Health Claim, including the applicable diagnosis and treatment codes (and their meanings).

- *For Post-Service Claims only*: a statement of your right to request a voluntary second-level review by the Board of Trustees, including a description of the review process.

- A statement of your right to request an external review by an independent review organization, including a description of the external review process.

- A statement of the Claimant's right to bring an action under ERISA Section 502(a) following the denial of the Health Claim on appeal.

- If applicable, a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal and that a copy of such specific rule, guideline, protocol, or other criterion will be provided to you, free of charge and upon request.

- If the denial of a Health Claim is based on a medical necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request.

This concludes the internal claims and appeals procedures with respect to Health Claims under the MLK Program.

H. Recourse After Denial of Health Claim on Appeal

If your Health Claim is denied on appeal, in whole or in part, you may bring an action for benefits under ERISA Section 502(a).

Optional Review Procedures (Not Required). Before bringing an action under ERISA Section 502(a), however, you also have the following voluntary, no-cost options:

- Voluntary Second-Level Review of Post-Service Claims: If, after exhausting the internal claims and appeals process through DBA, your Post-Service Claim continues to be denied, in whole or in part, you may (but are not required to) submit your appeal to the Administrative Office of the Fund for a voluntary second-level review by the Board of Trustees in accordance with the procedures shown below in subsection I.

If your Post-Service Claim is denied following voluntary second-level review, you may either (i) bring an action under ERISA Section 502(a); or (ii) if applicable, request an external review of your Health Claim, as described below in subsection J. If the Health Claim is denied on external review, you may then choose to bring an action under ERISA Section 502(a).

- External Review Process: Under certain circumstances, you can request that the Health Claim be reviewed by an independent review organization in accordance with the Plan's external review process shown below in subsection J. If the Health Claim is denied on external review, you may then choose to bring an action under ERISA Section 502(a).

I. Voluntary Second-Level Review (Post-Service Claims Only)

If your Post-Service Claim is denied on appeal, you may (but are not required to) submit a written request to the Board of Trustees asking for a voluntary second-level review of the denial (also referred to as a "second appeal"). There is no cost to you for requesting a voluntary second-level review.

Submitting your dispute to voluntary second-level review will toll (i.e., suspend) the time limits for requesting any available external review or bringing an action under ERISA Section 502(a).

You will be provided, upon written request, information relating to the voluntary second-level review process, including (1) a statement that your decision to submit a dispute to voluntary second-level review will have no effect on your rights to any other benefits under the MLK Program and (2) information about the applicable rules, your right to representation by your Authorized Representative, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker.

Requesting a Voluntary Second-Level Review.
Your request for a voluntary second-level review must be filed with the Administrative Office within 120 days after you receive the written appeal denial notice from DBA. A request is considered filed on the date it is received by the Administrative Office (or on the date postmarked, if mailed to the Administrative Office through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

Your request must be in writing and include your name, mailing address, telephone number, and the basis for your second appeal. You may submit any written comments, documents, records, evidence, testimony, and other information relating to your Post-Service Claim to support your request for a second review.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Post-Service Claim.

Processing a Voluntary Second-Level Review.
Your second appeal will receive a full and fair review by the Board of Trustees. The Board will consider all of the written comments, documents, records, evidence, testimony, and other information submitted by you that relates to your Post-Service Claim, regardless of whether such information was submitted or considered in the initial review or appeal by DBA. You have no right to appear personally before the Board. The Board will exercise its reasoned discretion and authority in making, interpreting, and applying Plan rules, and in resolving any disputes.

Your second appeal will be decided at the Board meeting that occurs at least 30 days after the date your request is filed. The time for deciding your second appeal may be extended to the third meeting after your request is filed if special circumstances require an extension of time for processing, or longer if you are asked to submit information necessary to make a determination on your second appeal. You will be notified in writing of any extension before it is taken, the reason for the extension, and the date a decision is expected. If asked to submit information necessary to decide the second appeal, you will be given at least 45 days to respond, and the time for the Board's decision will be suspended from the date of the extension notice until the earlier of the date you respond or the due date set by the Board. You may voluntarily agree to extend the time for the Board to process your second appeal.

You will be provided with a written notice of the decision within 5 days after the Board makes its decision.

If your Post-Service Claim is denied following voluntary second-level review, in whole or in part, you will receive a written denial notice that contains the information described above in subsection G. of these claims and appeals procedures.

Recourse After Denial. If your Post-Service Claim is denied following voluntary second-level review, you may bring an action under ERISA Section 502(a) or, if applicable, you may request an external review of your Health Claim, as described below in subsection J. If the Health Claim is denied on external review, you may then choose to bring an action under ERISA Section 502(a).

J. External Review Process

This voluntary external review process is intended to comply with the Affordable Care Act (ACA) external review requirements.

What Is External Review?
You may request an external review of your Health Claim after it has been denied on appeal by DBA or following the denial of a voluntary second-level review by the Trustees.

External review is conducted by an accredited independent review organization ("IRO") that is independent of the Plan. When you request an external review, DBA will turn over all related information to the IRO conducting the external review. There is no cost to you for requesting external review.

Applicability
External review is only available in certain cases. You may seek external review of your denied Health Claim by an Independent Review Organization (IRO) if all the following requirements are satisfied:

- The denial either (1) involves medical judgment (as determined by the IRO), including, but not limited to, those based on the MLK Program's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is Experimental or Investigational, or (2) concerns a Rescission of Coverage, regardless of whether the rescission has any effect on any particular benefit at that time.

- The denial was not based on ineligibility for coverage.

- You have exhausted (or are "deemed" to have exhausted) the MLK Program's internal claims and appeals procedures described above. *Note: You are not required to submit your dispute to voluntary second-level review as described above in subsection I. before requesting external review*.

- You have provided all of the information and forms required to process an external review.

External review is not available for any other types of denials.

Types of External Review
There are two types of external review outlined below: standard external review (for non-urgent Health Claims) and expedited external review (for Urgently Needed Care Claims). There are special rules for expedited external review, including eligibility and timing requirements, which are described in more detail below.

Standard External Review (For Non-Urgent Health Claims)

Requesting External Review. Your request for external review must be made in writing and must be submitted to DBA within four (4) months of the date of your appeal denial notice.

Preliminary Review by the Plan. Within five (5) business days of the DBA's receipt of your request, DBA will complete a preliminary review to determine whether your request is eligible for external review by considering the following factors:

- Whether you are/were covered under the MLK Program at the time the health care item or service is/was requested or provided;

- Whether the adverse determination satisfies the above-stated requirements for external review (i.e., the denial involves medical judgment or there has been a Rescission of Coverage) and does not, for example, relate to (1) your failure to meet the requirements for eligibility under the terms of the Plan, (2) a denial that is based on a contractual or legal determination, or (3) a failure to pay premiums causing a retroactive cancellation of coverage;

- Whether you have exhausted (or are deemed to have exhausted) the MLK Program's internal claims and appeals procedures; and

- Whether you have provided all of the information and forms required to process an external review.

Notice from the Plan. Within one (1) business day of completing its preliminary review, DBA will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you that your request is:

- Complete and eligible for external review; or

- Complete but not eligible for external review, in which case the notice will state the reasons for ineligibility and include contact information for the Employee Benefits Security Administration (toll-free at (866) 444-EBSA (3272)); or

- Not complete, in which case the notice will describe the information or materials needed to complete the request. You will be allowed to complete the request for external review within the four-month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review by an Independent Review Organization (IRO). If the request is complete and eligible for external review, DBA will assign the request to an IRO, which will conduct the external review. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. DBA may rotate assignment among IROs with which it contracts.) Once the Health Claim is assigned to an IRO, the following procedures will apply:

- The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your Health Claim (generally, you are to submit such information within ten (10) business days).

- Within five (5) business days after the external review is assigned to the IRO, DBA will provide the IRO with the documents and information that it considered in making its adverse determination. If DBA fails to comply with this requirement, the IRO may terminate the external review and reverse DBA's decision, in which case the IRO will notify you and DBA within one (1) business day after making its decision.

- If you submit additional information related to your Health Claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to DBA. Upon receipt of any such information, DBA may reconsider its adverse determination that is the subject of the external review. Reconsideration by DBA will not delay the external review. However, if upon reconsideration, DBA reverses its adverse determination, DBA will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the Health Claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the MLK Program's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO's decision is not contrary to such terms, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the MLK Program's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

- In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating Providers, other information from you or DBA, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the MLK Program's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer(s) and/ or legal expert(s).

Notice of Decision from IRO. The assigned IRO will provide written notice of its final external review decision to you and DBA within 45 days after the IRO receives your request for external review.

If the IRO reverses the MLK Program's adverse determination, upon DBA's receipt of the notice of such reversal, the MLK Program will immediately provide coverage or payment for the reviewed Health Claim. However, even after providing coverage or payment for the Health Claim, the MLK Program may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the MLK Program's adverse determination, the MLK Program will continue not to provide coverage or payment for the reviewed Health Claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

The assigned IRO's decision notice will contain the following:

- A general description of the reason for the request for external review;
- Information sufficient to identify the Health Claim (including the date(s) of service, the Provider, the Health Claim amount (if applicable), and the reason for the previous denial);
- The date that the IRO received the request to conduct the external review and the date of the IRO's decision;
- References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- A statement that the IRO's determination is binding on the MLK Program (unless other remedies may be available to you or the MLK Program under applicable State or Federal law); and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

K. <u>Expedited External Review (for Urgently Needed Care Claims)</u>

Applicability. You may request an expedited external review if:

- Your initial Health Claim denial involves a medical condition for which the time frame for completion of a standard external review would seriously jeopardize the patient's life or health, or would jeopardize the patient's ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- The denial of your Health Claim on appeal involves a medical condition (a) for which the time frame for completion of a standard external review would seriously jeopardize the patient's life or health or would jeopardize the patient's ability to regain maximum function, or (b) that concerns an admission, availability of care, continued stay, or health care item or service for which the patient received Emergency Services, but the patient has not yet been discharged from the facility.

The rules applicable to standard external review, shown above, also apply to expedited external review, subject to the following exceptions:

- **Preliminary Review.** Immediately upon receipt of a request for expedited external review, DBA will complete its preliminary review and notify you (e.g. via telephone, fax) as to whether your request for review meets the preliminary review requirements.

- **Review by an Independent Review Organization (IRO).** After the external review is assigned to the IRO, DBA will expeditiously (e.g. via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the IRO the documents and information that it considered in making its Adverse Determination. The IRO will provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and DBA.

12. Additional Rules Applicable to Claims and Appeals

A. Physical Examinations

The MLK Program reserves the right to have a physician of its own choosing examine any Participant whose Illness or Injury is the basis of a Health Claim or appeal. Any such examinations shall be at the expense of the MLK Program. This right may be exercised when and as often as reasonably required during the pendency of a Health Claim or appeal. The Participant must comply with this requirement as a necessary condition to coverage.

B. Assignments (Out-of-Network Providers).

Covered Expenses for care, supplies, or services provided by an Out-of-Network Provider may be assigned by a Participant to the Out-of-Network Provider; however, if those benefits are paid directly to the Participant, the MLK Program shall be deemed to have fulfilled its obligations with respect to such benefits. The MLK Program will not be responsible for determining whether any such assignment is valid.

No right of any Participant under the MLK Program, other than the right to the reimbursement of covered medical expenses, may be assigned to any party, including a Provider. Any attempt to assign any such right, including but not limited to the right to appeal the denial of a Health Claim under the MLK Program, the right to name an Authorized Representative for the purpose of an appeal, or the right to file an action in court related to a Health Claim under the MLK Program, shall be null and void.

Notwithstanding the above, in the event the MLK Program determines that you cannot submit a Health Claim or prove that you paid for health care services that are covered under the MLK Program because you are incompetent or incapacitated, the MLK Program may, at its discretion, pay benefits directly to the Out-of-Network Provider who provided the health care services or supplies, or may pay benefits to any other individual who is providing for your care and support. Any such payment of benefits will completely discharge the Fund's obligations to the extent of the payment. Neither the MLK Program, the Fund, the Board of Trustees, the Claims Administrator, nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

C. Coverage of an Alternate Course of Treatment

The Plan Administrator may, in its sole discretion, determine that a service or supply, not otherwise covered under the MLK Program, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, covered service or supply. Payment for such service or supply will be considered as being in accordance with the terms of the MLK Program.

If a covered Participant, in cooperation with his or her Provider, elects a course of treatment that is deemed by the Plan Administrator, in its sole discretion, to be more extensive or costly than is Medically Necessary to satisfactorily treat the Illness or Injury, the MLK Program will allow coverage for the value of the less costly or extensive course of treatment only.

D. Recovery of Overpayments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the MLK Program's terms, conditions, limitations or exclusions. Whenever the MLK Program pays benefits exceeding the amount of benefits payable under the terms of the MLK Program (an "overpayment"), the Fund has the right to recover the overpayment from any person or organization to, or for, whom said payments were made or from any person whose acts, omissions, or representations caused the overpayment. In the event the Fund brings legal action to recover any such overpayment, the Fund shall be entitled to recover its costs and attorney's fees incurred in such action.

A Participant, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan, or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Fund within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

When a Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Health Claims for services provided to the Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the MLK Program, by the amount due as reimbursement to the MLK Program. Any such reductions shall not exceed the amount of the overpayment required to be reimbursed.

E. Claims Submission Requirements

Providers and any other person or entity accepting payment from the MLK Program, in consideration of such payments, agree to be bound by the terms of this MLK Program, and are required to submit claims for reimbursement in accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other forms or standards approved by the Board of Trustees.

13. Coordination of Benefits

This Section describes the MLK Program's coordination of benefits rules.

These coordination of benefits ("COB") rules apply when the MLK Program/Fund processes a Claim for benefits of a Participant in the MLK Program who also has health coverage under a plan, policy or program that is not provided by the Fund (referred to as "Other Coverage").

Other Coverage includes, but is not limited to, coverage under a group health plan, insurance policy or contract, program, or other arrangement that provides payment or reimbursement for Hospital, medical, prescription drug, mental health and/or substance abuse, dental, and/or vision expenses; and the medical care components of a long-term care contract, such as skilled nursing care.

Special rules (see below) apply to coordination of coverage with Medicare, Medicaid (Medi-Cal), a state Children's Health Insurance Program (CHIP), TRICARE, and any other federal or state governmental plan, for which the Fund is permitted or required by law to coordinate benefits.

Other Coverage **does not include:** (1) coverage under an individual (i.e., non-group) plan or policy; (2) medical benefits under a motor vehicle insurance contract; (3) blanket insurance contracts issued pursuant to Section 10270.2(b) or (e) of the California Insurance Code which contain a non-duplication of benefits or excess policy provision; (4) Medicare supplement policies; or (5) coverage under other federal or state governmental plans, unless coordination with such coverage is permitted by law.

COB rules are used to determine: (1) whether the MLK Program is primary (and pays benefits first, without regard to the Other Coverage) or secondary (and pays benefits second, after the Other Coverage pays); and (2) the limits on the Fund's payment obligations when the MLK Program is secondary.

A. Order of Benefit Determination

For the purposes of Coordination of Benefits, the rules for establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed to determine which plan is primary and pays first and which plan is secondary and pays second, and will apply the first rule applicable to the circumstances of the Claim.

(1) If the Other Coverage does not have COB rules, then it will always be the primary plan;

(2) The plan that covers the Participant other than as a dependent is the primary plan, and the plan that covers the Participant as a dependent is the secondary plan.

(3) If the Participant is an inactive employee (e.g., retired or on layoff) or the dependent of an inactive employee, the benefits of the plan covering the person as an active employee, or the dependent of an active employee, will be primary and the benefits of the plan covering the Participant as an inactive employee will be secondary.

(4) If the Participant is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

a. When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the child has not remarried, the benefits of the plan which covers the child as a dependent of the parent with custody will be primary to the benefits of a plan which covers the child as a dependent of the parent without custody; or

b. When the parents are separated (whether or not ever legally married) or divorced and the parent with custody of the child has remarried, the order of benefit determination among the plans of the parents and their spouses (if any) is:

(i) The plan of the custodial parent pays first; and
(ii) The plan of the spouse of the custodial parent pays second, and
(iii) The plan of the non-custodial parent pays third; and
(iv) The plan of the spouse of the non-custodial parent pays last.

c. Regardless of the foregoing, when the parents are separated (whether or not ever legally married) or divorced, the benefits of a plan of a parent subject to a court order establishing such parent's financial responsibility to provide medical coverage or medical care for a child, shall be primary to the benefits of any other plan covering the child as a dependent.

(5) If a Participant whose coverage is provided under a right of continuation under federal or state law (e.g., COBRA coverage) also has Other Coverage that is not provided under such a right of continuation, the plan that is not continuation coverage pays first, and the plan providing continuation coverage to that same Participant pays second;

a. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(6) When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the Participant for the longer period of time shall be primary and the plan which has covered such Participant the shorter period of time will be secondary.

(7) If none of the previous rules determines which plan pays first, each plan will pay an equal share of the allowed expenses incurred by the Participant. For purposes of determining this Fund's share under this rule, "allowed expenses" means the MLK Program's Normal Benefit (as defined in subsection 13.B. below) for the service(s) provided.

B. Application to Benefit Determinations

When the MLK Program is primary to the Other Coverage, the Fund will pay the amount that it would have paid if there had been no Other Coverage involved (the MLK Program's "Normal Benefit").

When the MLK Program is secondary to the Other Coverage (i.e., the Other Coverage is primary), then benefits payable by the MLK Program will be determined as follows, but are subject to the MLK Program's benefit provisions where many services are covered only when provided by MLK Community Medical Group and/or when a Referral and Prior Authorization are obtained:

- If the amount paid by the Other Coverage is *the same as or greater than* the Normal Benefit provided under the MLK Program, then the Fund will not pay any benefits.

- If the amount paid by the Other Coverage is *less than* the Normal Benefit provided under this Plan, then the Fund will pay the difference between its Normal Benefit and the amount paid by the Other Coverage, but only to the extent of any patient responsibility under the Other Coverage. However, in no event will the MLK Program pay more than it would have in the absence of Other Coverage.

However, the Fund will not coordinate with Health Maintenance Organization ("HMO") plans, regardless of which plan is considered to be the primary payer, unless required to do so by federal law. In other words, the Fund will not reimburse HMO copays or deductibles, even if the copays or deductibles under the Other Coverage are higher than the copays or deductibles that apply under the MLK Program. Further, when an HMO plan would be primary and the covered Participant does not use an HMO provider, the MLK Program will not consider as Covered Expenses any charge that would have been covered by the HMO had the Participant used the services of an HMO Provider.

When there is a conflict in the order of benefit determination, as described in (7) under Order of Benefit Determination, the MLK Program will never pay more than 50% of allowable expenses, as determined under the MLK Program.

14. Coordination of Benefits with Medicare, Medi-Cal and Other Federal Benefits

A. Coordination of Benefits with Medicare

If a Participant in the MLK Program also has Medicare coverage, the Fund will apply the following Medicare Secondary Payer (MSP) rules to determine whether Medicare is primary to the Plan:

(1) Age-Based Medicare Entitlement: For a Participant whose entitlement to Medicare is based on age:

(a) If the Participant has Fund coverage due to an Employee's current employment status, this Plan is primary to Medicare.

(b) If, however, the Participant has COBRA coverage under the Fund, Medicare will be primary to this Plan.

(2) Disability-Based Medicare Entitlement: For a Participant whose entitlement to Medicare is based on disability:

(a) If the Participant has Fund coverage due to an Employee's current employment status, this Plan is primary to Medicare.

(b) If, however, the Participant has COBRA coverage under the Fund, Medicare will be primary to this Plan.

(3) Medicare Entitlement Based on End-Stage Renal Disease: For a Participant whose eligibility or entitlement to Medicare is based on end-stage renal disease (ESRD):

(a) This Plan is primary to Medicare for the first 30 months of ESRD-based Medicare eligibility or entitlement (following a three-month waiting period). Then, starting with the 31st month after the start of ESRD-based Medicare eligibility or entitlement, Medicare is primary to this Plan.

(b) If Medicare was already primary by reason of subsection (1) or (2), Medicare will remain primary regardless of the rules of subsection (3).

When a Participant is covered by the MLK Program and is also covered by Medicare Parts A and/or B, and the MLK Program is secondary to Medicare, the Fund pays the difference between its Normal Benefit and the amount paid by Medicare, but only to the extent of any patient responsibility under Medicare. In determining the amount of the MLK Program's Normal Benefit for purposes of coordination with Medicare, the Fund uses the lesser of: (1) its contracted rate with the Provider (or the Allowed Amount for a Covered Expense from an Out-of-Network Provider) or (2) the fees allowed by Medicare (i.e., Medicare's allowed amounts) and does not use the billed charges of the Health Care Provider. In no case, however, will the Fund pay more than the regular benefit (i.e., the same benefit amount provided under the MLK Program for active Employees). If the amount paid by Medicare is the same as or greater than the Plan's Normal Benefit, then the Fund will not pay any benefits. If the Provider does not accept Medicare, then the Fund will not pay any benefits.

B. Coordination of Benefits with Medi-Cal and Other Federal Benefits

In all cases, benefits available through Medi-Cal, any other state or Federal Medicaid program, or a State Children's Health Insurance Program (CHIP), will be secondary or subsequent to the benefits of the MLK Program.

15. Additional Rules Applicable to Coordination of Benefits

A. Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of the MLK Program's Coordination of Benefits provisions or any provision of similar purpose of any other plan, the MLK Program may release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the MLK Program deems to be necessary for such purposes. Any person claiming benefits under the MLK Program shall furnish to the MLK Program such information as may be necessary to implement this provision.

B. Facility of Payment

Whenever payments which should have been made under the MLK Program in accordance with this provision were instead made by another plan, the Claims Administrator may, in its sole discretion, pay any plan or entity making such erroneous payments the amount it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this MLK Program and, to the extent of such payments, this MLK Program shall be fully discharged from liability.

C. Right of Recovery

Whenever payments have been made by the MLK Program that exceed the amount of payment necessary to satisfy the Plan's Coordination of Benefits provisions, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Overpayments provision of this MLK Program.

16. Subrogation, Third-Party Recovery and Reimbursement

If any benefits are payable to you or any Dependent (for the purposes of this section, "you" includes both an eligible Employee and a Dependent) under the Plan with respect to any injury, illness, or death caused by a third party, you agree that the Fund shall be reimbursed out of any amounts you (or any successor(s) in interest, including but not limited to a parent, an heir, an estate, guardian, or personal representative) recover from any party alleged to have caused or contributed to such injury, illness, or death, or any insurer or other person acting on behalf of such a party. The Fund shall have a first-dollar lien against the entire amount of any such recovery, to the extent of all benefits paid or payable under the MLK Program to you with respect to any injury, illness, or death for which you recover any money, whether as a result of a judgment, settlement, or other award or monetary payment. The Fund's lien and right to reimbursement has first priority against the entire recovery even if you are not compensated for all your losses or damages, and even if some or all of the recovery is attributed to damages other than medical expenses for you.

The Fund's lien shall not exceed the full amount that the MLK Program has paid for benefits related to your injury, illness or death. No lien shall apply to any amount received under any uninsured motorist or underinsured motorist coverage in any policy of insurance on which the injured party is a named insured.

Whenever you submit a claim for benefits, you must notify the Fund if you believe a third party may be responsible or at fault for any illness, injury or death. You must also do whatever is necessary to secure the reimbursement and lien rights of the Fund. You shall:

(1) Promptly notify the Fund when you file a claim or lawsuit related to any injury, illness or death for which benefits are payable under the MLK Program, against an allegedly responsible third party;

(2) Sign and execute the Fund's reimbursement agreement and acknowledgment of lien;

(3) Promptly respond to any requests for information from the Fund regarding your claim or lawsuit; and

(4) Promptly notify the Fund when a recovery is obtained from any source, and reimburse the Fund. This must be done before the recovery is paid to anyone else, including you.

The Fund may suspend or offset benefits otherwise payable to you under the MLK Program in order to secure and satisfy its lien. Your failure to sign the reimbursement agreement and lien acknowledgment shall not constitute a waiver of the Fund's right to reimbursement or lien. In addition, if you fail to comply with any of the MLK Program's requirements for securing the Fund's reimbursement and lien rights, the Fund has the right to take legal action against you. The Fund may also file notice of its lien and reimbursement rights with any person affected by them, including but not limited to the court in which any action is filed, the attorney representing you, and the third party allegedly responsible for the injury, illness or death giving rise to the action for recovery.

The Trustees or their designee may accept less than the full amount of benefits paid or payable under the MLK Program in satisfaction of the Fund's lien. The Administrator is authorized to reduce the Trust Fund's lien in circumstances where the net recovery (as defined below) does not exceed $100,000.00. Specifically, the Fund will accept the lesser of:

A. Two-thirds of the Fund's lien; or
B. Fifty percent of the first $25,000 of any net recovery, plus 75% of any excess.

"Net recovery" means the total amount paid or payable to or on behalf of an injured party, less attorney's fees and litigation costs actually expended by or on behalf of the injured party.

An injured party, or an attorney acting on his or her behalf, may request further reduction of the lien and reimbursement obligation hereunder by request to the Board of Trustees (in the case of recoveries exceeding $100,000.00, the initial request for reduction shall be made to the Board of Trustees). The Board of Trustees will review any information, documents, and discussion submitted in determining the appropriateness of any requested reduction in the Fund's lien. Factors for consideration may include loss of earnings, out-of-pocket expenses, anticipated unreimbursed future medical expenses, the permanence of the injuries, and the impact of the injuries on future employment, earning potential, and quality of life.

Regardless, the Fund shall not make any reduction in its lien if: (1) the Fund becomes involved in any litigation or other legal proceedings to enforce its lien or to recover any amount which you are required to reimburse to the Fund, or to defend against any claim related to the Fund's reimbursement and lien rights, or (2) if the Board of Trustees determines that you, or your attorney, has attempted to evade or avoid the Fund's lien. Evasion and avoidance of the lien include, but are not limited to, the failure to advise the Fund that any injury, illness or death was caused by a third party, the failure to execute the Fund's reimbursement agreement and acknowledgment of the Fund's lien, or the failure to timely notify the Fund of any recovery.

When a Covered Person Does Not Comply
When a Participant does not comply with the provisions of this section, the Fund may deny payment of any Claims and deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the MLK Program by the amount of the Fund's lien. If the Fund brings an action against a Participant to enforce the provisions of this section, the amount of the Fund's lien shall include the Fund's attorneys' fees and costs.

17. Workers Compensation

The MLK Program does not provide benefits for treatment of illnesses or injuries that are covered by Workers' Compensation or occupational disease laws.

If you or your enrolled Dependent (referred to in this Article as "the injured Participant") experience a work-related illness or injury (including but not limited to being injured while at work), the injured Participant should file a workers' compensation claim with his or her employer. If the employer denies the workers' compensation claim, the injured Participant must appeal the denial through his/her employer's workers' compensation carrier. The injured Participant's appeal must be filed with a Division of Workers' Compensation District Office, also known as the Workers' Compensation Appeals Board office, as an Application for Adjudication.

In order for a claim related to a work-related illness or injury to be considered for payment by the MLK Program, the injured Participant must submit a copy of (1) the denial notice from his or her employer, and (2) the Application for Adjudication, to the Administrator. The Fund will file a Notice and Request for Allowance of Lien with respect to any expenses for the treatment of any work-related illnesses or injuries alleged to be covered under workers' compensation or occupational disease law. The Fund's Notice and Request for Allowance of Lien will be issued to the injured Participant for signature. Upon receipt of the injured Participant's signature for the Fund's Notice and Request for Allowance of Lien, any pending claims related to the injured Participant's work-related illness or injury will be processed under the MLK Program and the Fund will seek satisfaction of its lien through the Workers' Compensation Appeals Board.

YOU ARE REQUIRED TO NOTIFY THE PLAN ADMINISTRATOR IMMEDIATELY WHEN YOU FILE A CLAIM FOR COVERAGE UNDER WORKERS' COMPENSATION IF A CLAIM FOR THE SAME INJURY OR ILLNESS IS OR HAS BEEN FILED WITH THE MLK PROGRAM.

18. Plan Administration of the MLK Program

Authority to Make Decisions in Connection with The MLK Program

As provided elsewhere in this SPD, the Trustees have full discretionary authority to determine eligibility for benefits, to administer, apply and construe the terms of the Plan, including the MLK Program and the SPD; and to decide all matters arising in connection with the operation or administration of the Fund, including the MLK Program.

The Trustees have retained the services of DBA, the Claims Administrator, to provide certain claims processing and other administrative services to the MLK Program. In addition, the Board of Trustees has delegated its authority to decide internal appeals to DBA, the Claims Administrator. The decision of DBA shall be conclusive and binding to all persons. However, if a disputed Health Claim is submitted to the voluntary second-level review process or the external review process, the decision of the Trustees or the IRO (as applicable) will be final, except as other remedies may be available under State or Federal law following a decision on external review. Notwithstanding the foregoing, the Trustees retain the right and authority to direct DBA's decision making with respect to any appeal, including with respect to the interpretation of the Plan and the MLK Program, and all rules relating thereto.

Except in the limited circumstances where a disputed Health Claim has been submitted to an IRO under the external review process, the decisions of the Board of Trustees (or, as applicable, its designee, DBA), as to the facts related to any Claim for benefits (or appeal of a disputed Claim) and the meaning and intent of any provision of the MLK Program, or its application to any Claim, will be final and binding on all interested parties and are intended to receive the deference provided by law to the acts of Trustees acting within their discretionary authority.

Right to Amend the MLK Program

In accordance with the terms of the Trust Agreement, the Board of Trustees may, in its sole discretion, amend or terminate the Plan, including the MLK Program, at any time. Plan amendments may result in reduction or elimination of benefits or changes in eligibility rules. All amendments to the MLK Program shall become effective as of a date established by the Trustees.

V. HEALTH NET OF CALIFORNIA PLAN
(You Must Use Network Providers)

Internet (information about Health Net network providers): **http://www.healthnet.com**

Health Net's Customer Contact Center
(8:00 a.m. to 6:00 p.m. Monday through Friday): (800) 522-0088 (TTY: 711)

SIMNSA Network (FOR SERVICES IN MEXICO): (011-52-664) 683-29-02 or 683-30-05
or (800) 424-4652

IMPORTANT (PLEASE READ): The information in this booklet describing the Health Net of California, Inc. Plan (also referred to as the "Health Net Plan") is for your convenience and is not intended to be a complete description of the Health Net Plan. *For detailed information about the Health Net Plan, including information on covered services, cost sharing, exclusions and limitations, and the procedures for filling claims and appeals, please refer to Health Net's Evidence of Coverage (the "EOC"), which has been prepared by Health Net specifically for the Fund. If there is a conflict between any description of Health Net benefits in this booklet and the Health Net's EOC or the Fund's contract or policy with Health Net, the EOC or the contract or policy with Health Net will control. Please call Health Net at the telephone number listed on the Reference Chart at the beginning of this booklet for a copy of the EOC.*

1. About the Health Net of California, Inc. Plan

The Health Net of California, Inc. Plan is an HMO medical plan provided by Health Net, Inc., which has contracted with the Fund to provide you and your Dependents with comprehensive healthcare coverage, including medical, hospital, mental/behavioral health, and substance abuse benefits. *(The Health Net Plan does not provide coverage for outpatient prescription drugs. For information on prescription drug coverage, please see "The Prescription Drug Program Provided Through Express Scripts" under Article VII of this SPD.)*

Service Area. The Health Net Service Area encompasses certain regions in Southern California and Mexico (Baja California within fifty miles of the California-Mexico border). Coverage is generally not provided to enrollees outside of the Health Net Service Area, except in cases of Emergency or Urgently Needed Care.

Network Providers. You must use network providers or there is no coverage, except for the following: (1) Emergency or Urgently Needed Care; (2) referrals to non-network providers (e.g., specialists) when issued by your in-network doctor; and (3) covered services provided by a non-network provider when authorized by the Salud HMO y Mas Network or SIMNSA.

The Health Net Plan offers the following two provider networks:

- The Salud HMO y Mas network in Southern California (referred to as the "Salud Network"); and
- The SIMNSA network in Mexico (the "SIMNSA Network").

Be aware, your network provider might use an out-of-network provider for some services (such as lab work). You should always check to make sure your provider is in either the Salud Network or the SIMNSA Network before you get services.

2. Designating a Primary Care Physician and a Salud Network Physician Group (California's Salud Network Only)

For you and your Dependents who live in California (Salud Network): You and your Dependents who live in California must each designate a Primary Care Physician ("PCP") and a Salud Network Physician Group (also called a "Participating Physician Group") within the Salud Network. Your PCP will work within your Participating Physician Group and provide and coordinate your medical care. Until you make this designation, Health Net designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Health Net at (800) 522-0088 or you may call the number shown on the back of your Health Net I.D. Card. You can also visit the Health Net website at www.healthnet.com.

- Your Participating Physician Group must be close enough to your home or workplace to allow for reasonable access to medical care. Note that some Participating Physician Groups may decline to accept assignment of an enrollee whose home or work address is not close enough to allow reasonable access to care.
- You and your Dependents may have different PCPs and different Participating Physician Groups.
- For children, a pediatrician may be designated as the PCP.
- You may change your PCP up to once per month by calling Health Net.
- Until you make a PCP and Participating Physician Group designation, Health Net designates one for you.

For your enrolled Dependents who live in Mexico (SIMNSA Network): There is no requirement to designate a PCP or Participating Physician Group in the SIMNSA Network.

Please call Health Net's Customer Contact Center or SIMNSA if you need a Provider Directory, to request provider information, or if you have questions involving reasonable access to care. SIMNSA Members may contact SIMNSA. You can also visit Health Net's website at www.healthnet.com/providersearch for a list of participating providers.

3. How to Obtain Care

For you and your Dependents who live in California (Salud Network): In general, your PCP and Participating Physician Group will provide or authorize all of the medical care that you receive in California.

- You can call your PCP directly to make an appointment.
- **Specialists.** If you need medical care that your PCP or Participating Physician Group cannot provide, you will need a referral to a specialist or other health care provider from your PCP or Participating Physician Group. Once you get approval to receive specialist services, you can call the specialist's office to schedule an appointment.
- **In Mexico.** You and your Dependents who live in California may also obtain covered services in Mexico from any contracting Physician Group in the SIMNSA Network.

For your enrolled Dependents who live in Mexico (SIMNSA Network): Your enrolled Dependents who live in the Health Net Service Area in Mexico can go to any contracting Physician Group in the SIMNSA Network.

- They must use SIMNSA providers, except in the case of Emergency or Urgently Needed Care.

- **Specialists.** They do not need a referral or prior authorization to see a specialist. In order to receive care from providers outside the SIMNSA Network, however, they must first obtain authorization from SIMNSA, except for Emergency or Urgently Needed Care.

- **In California.** They may not receive any services in California, except for Emergency or Urgently Needed Care.

A. Triage and/or Screening/24-Hour Nurse Advice Line

If you are sick and cannot reach your doctor, like on the weekend or when the office is closed, you can call Health Net's Customer Contact Center at the number shown on your Health Net I.D. Card, and select the triage and/or screening option. You will be connected to a health care professional (such as a doctor, nurse, or other provider, depending on your needs) who will be able to help you and answer your questions 24 hours per day, 7 days per week.

B. Emergency Care

For Emergency Care, you can go to the nearest hospital, regardless of whether the hospital is in network or not, but it is critical that you contact your Salud Network PCP or Physician Group in California, or your SIMNSA Provider in Mexico, as soon as you can after receiving emergency services from others outside your Physician Group. Your Salud Network PCP or SIMNSA Physician Group will evaluate your circumstances and make all necessary arrangements to assume responsibility for your continuing care.

4. Benefits and Cost Sharing

For detailed information about benefits and cost sharing under the Health Net Plan, please refer to Health Net's Evidence of Coverage, which is available without charge from Health Net and the Administrative Office.

5. Plan Exclusions

For a complete list of the conditions, services, and products that are not covered under the Health Net Plan, please refer to the Plan's Evidence of Coverage, which is available from Health Net or the Administrative Office.

6. Claims and Appeals Procedures

All claims and appeals for benefits under the Health Net of California, Inc. Plan must be submitted to Health Net and will be processed in according to Health Net's claims and appeals procedures.

VI. THE KAISER HMO PLAN
(Must Use Kaiser Permanente Facilities & Physicians)

Internet: http://www/kp.org

Kaiser Permanente Member Services (24 hours, 7 days a week):
(800) 278-3296 (TTY: 711)

IMPORTANT (PLEASE READ): This brief description of the Kaiser HMO Plan is included in this booklet for your convenience. It is not intended to be a complete description of the Kaiser HMO Plan. *For detailed information about the Kaiser HMO Plan, including information on covered services, cost sharing, exclusions and limitations, and the procedures for filing claims and appeals, please refer to the Kaiser Permanente Evidence of Coverage (the "EOC"). If there is a conflict between any description of the Kaiser HMO Plan's benefits contained in this booklet and Kaiser's EOC or the Fund's contract with Kaiser, the EOC or the contract with Kaiser will control. Please call Kaiser Customer Service at the telephone number listed on the Reference Chart at the front of this booklet for a copy of the EOC.*

1. About the Kaiser HMO Plan

The Kaiser HMO Plan is an HMO medical plan provided through the Kaiser Foundation Health Plan (Kaiser"), which has contracted with the Fund to provide you and your Dependents with comprehensive health care coverage, including medical, hospital, mental/behavioral health, and substance abuse benefits. *(The Kaiser HMO Plan generally does not provide coverage for outpatient prescription drugs. For information on prescription drug coverage, please see "The Prescription Drug Program Provided Through Express Scripts" under Article VII of this SPD.)*

When you enroll in Kaiser, you must receive services from Kaiser Permanente health care providers at Kaiser facilities. If you do not receive services from Kaiser providers, you will be responsible for 100% of the charges (except in the case of an Emergency, in which case Kaiser will determine how much it will pay). You can call Kaiser or visit Kaiser's website if you would like to make an appointment or find a Kaiser personal physician.

Generally, you will need a referral from a Kaiser physician to see a specialist. However, you don't need referrals for certain specialties, like obstetrics-gynecology.

If you ever need Emergency Care, you can get care at the Emergency Room of a nearby hospital (even if it is not a Kaiser Hospital), and you do not need a referral or preauthorization.

2. Benefits and Cost Sharing

For detailed information about benefits and cost sharing under Kaiser HMO Plan, please **refer to Kaiser's Evidence of Coverage** which is available without charge from Kaiser Permanente Customer Service at (833) 574-2273

3. Plan Exclusions

For a complete list of the conditions, services, and products that are not covered by the Kaiser HMO Plan, please refer to Kaiser's Evidence of Coverage, which is available from Kaiser.

4. Claims and Appeals Procedures

All claims and appeals for benefits under the Kaiser HMO Plan must be submitted to Kaiser and will be processed in according to Kaiser's claims and appeals procedures, which are set forth in Kaiser's EOC.

VII. THE PRESCRIPTION DRUG PROGRAM PROVIDED THROUGH EXPRESS SCRIPTS

The Plan contracts with Express Scripts to provide prescription drugs for you and your Dependents.

Detailed information concerning the benefits provided under the Prescription Drug Program provided by Express Scripts are contained in the contract between Express Scripts and the Fund and in other program documents maintained by Express Scripts. If there is any conflict between the description of Prescription Drug benefits contained in this booklet and in the contract between Express Scripts and the Fund, or in other program documents maintained by Express Scripts, the terms of the contract or other governing program document will control.

Prescriptions must be filled at pharmacies contracted with Express Scripts in order to be covered by the Plan. These "contracted" pharmacies are called "network pharmacies." A list of network pharmacies in your area can be found on the Express Scripts website at http://www.express-scripts.com or you can call Express Scripts at (800) 606-5667. As described in Section 3, below, Accredo is the Plan's exclusive network pharmacy for specialty drugs, and all specialty drugs must be obtained through Accredo, except in case of urgent and immediate medical need. Any prescription obtained through a pharmacy not in the Express Scripts network will not be covered, except in case of an Emergency.

IMPORTANT: If you are taking a maintenance drug (one taken for more than 45 days) you must use the mail order Express Scripts Select Home Delivery program after the second refill at the retail pharmacy, unless you timely notify Express Scripts that you want to get your maintenance medication from a retail pharmacy. If you want to get your maintenance medication(s) from a retail pharmacy, you must inform Express Scripts of your choice before you need your third refill. Otherwise, you will be required use the home delivery mail order program.

To ensure proper use of certain drugs, some medications will now require prior authorization before they can be filled. If prior authorization is needed, your doctor or the pharmacy may contact Express Scripts to determine if the prescription meets the guidelines established for Fund benefits.

1. Retail Pharmacy Program

Go to your neighborhood chain store pharmacy (such as CVS or Rite Aid) or any other pharmacy contracted with Express Scripts **under their Select Network.** The Express Scripts website, http://www.express-scripts.com, provides more information about Express Scripts contracted pharmacies.

1. Identify yourself as eligible for prescription benefits by presenting your Express Scripts identification card to the pharmacist. The Plan covers only you and your Dependents as listed on your card.

2. The pharmacist will verify your eligibility with Express Scripts.

3. The pharmacist may also contact Express Scripts regarding prior authorization. If this occurs after normal business hours, you may have to wait until the next business day for your prescription. The Express Scripts prior authorization phone number is (800) 753-2851.

4. If the prescription is required immediately, you may pay for the prescription and submit a direct reimbursement claim form to the Administrative Office.

5. Retail prescriptions are limited to a 30-day supply. For maintenance medications, you can get up to a 90-day supply using mail order.

In accordance with your drug benefit program, for drugs purchased at a retail pharmacy your copayment per prescription is:

Retail (limited to 30-day supply):

Formulary Generic drugs	$3.00 copayment.
Brand Name drugs	$6.00 copayment

The pharmacist will provide generic drug substitution wherever available and allowed by your physician. The pharmacist will inform you when a generic substitution has been made. **If you do not wish a generic substitution, or if your doctor orders a brand name drug to be dispensed as written when there is a generic equivalent, the brand name drug will be dispensed, but you will have to pay the full difference in cost between the brand name and the generic drug, plus the applicable copayment.**

Warning: *If you get a brand name drug when a generic is available, you will pay the difference in price between the brand name and the generic drug, plus the applicable copay.*

2. Mail Order Pharmacy Program (for Maintenance Drugs)

If you are on one or more maintenance drugs (drugs that you expect to take regularly over a period of 45 days or more) you will use the mail order program to get your maintenance medications, unless you timely notify Express Scripts that you choose to receive your maintenance drug(s) from a retail pharmacy.

Your Mail Order Prescription Benefit is provided through the Express Scripts Select Home Delivery program. The Express Scripts Select Home Delivery program was designed to allow participants to receive larger quantities of maintenance medications (e.g. heart medication, blood pressure medication, diabetes medication, etc.) for less money.

For maintenance drugs, you must decide whether to use mail order or a retail pharmacy. When you are first prescribed a maintenance drug, you may fill the initial prescription, and one refill, at a local retail network pharmacy before you notify Express Scripts of your decision. If you don't inform Express Scripts of your decision, you will be required to use the mail order program.

If you choose to use the mail order program for your maintenance medications, you will save money.

In order to use the mail order program, you or your doctor must send your prescription to Express Scripts. You may call the Administrative Office for additional information and to obtain forms, or log in to http://www.express-scripts.com.

Your copayment when purchasing maintenance drugs through mail order will be:

Mail Order (up to 90-day supply):

Generic drugs	$3.00 copayment
Brand name drugs	$5.00 copayment

You can obtain up to a **90-day supply** of your maintenance prescription, if your doctor prescribes this quantity. Your cost is limited to the copayment shown above, unless your physician prohibits

generic substitution (a "dispense as written" prescription), or you choose a brand name drug instead of a generic equivalent. In these cases you will be responsible for the cost difference between the brand name drug and its generic equivalent.

You must obtain a new prescription from your doctor when your prescription expires, in order to continue receiving maintenance drugs through the Express Scripts Select Home Delivery program. Call your doctor promptly to assure that you have the new prescription when you need it. In general, you must send renewal prescription(s) to Express Scripts fifteen (15) days before you need them to receive the prescription before your supply runs out. After the first order, if your prescription includes refills, you can order your refills by telephone. You can also order refills and transfer medications from retail to mail order through www.express-scripts.com or the Express Scripts phone app.

3. Specialty Drugs: Exclusive Pharmacy for Specialty Drugs & SaveOn SP Copay Assistance Program

A. Accredo is the Exclusive Pharmacy for Specialty Drugs

Express Scripts identifies certain prescription drugs as *specialty* drugs. Typically, specialty drugs are prescription drugs that require professional administration or special handling, that have a high cost, or drugs used to treat rare or severe medical conditions. However, Express Script's determination of whether or not a prescription drug is a specialty drug is final with respect to the Plan. You may contact Express Scripts, at the number below, for more information about which drugs are specialty drugs.

Effective August 1, 2021, specialty drugs are generally not available through the Retail Pharmacy Program, except in case of urgent and immediate medical need. If you are prescribed a specialty drug, you must fill your prescription through the Plan's exclusive pharmacy for specialty drugs, Accredo. (In case of urgent and immediate medical need, you may fill a new specialty drug prescription at a Retail Pharmacy, but you must use Accredo thereafter.) If you are prescribed a specialty drug, Express Scripts will provide you with information on how to contact Accredo. As with other prescription drugs, prior authorization may be required before you can fill a prescription for a specialty drug through Accredo.

For more information or if you are prescribed a specialty drug, you may call Express Scripts at: (877) 248-1164 for assistance.

B. Increased Copays for Some Specialty Drugs; SaveOn SP Copay Assistance Program

In general, copays for specialty drugs are the same as for retail drugs under Section 1, above. However, effective October 1, 2021, the copayment for certain specialty drugs designated by Express Scripts as non-essential health benefits will substantially exceed those amounts. These designated specialty drugs, and the copay for each of them, may change from time to time. The designated specialty drugs and copays are maintained by Express Scripts on its SaveOn SP Drug list. You may contact Express Scripts for information about drugs on the SaveOn SP Drug list.

Effective October 1, 2021, if you are prescribed a specialty drug designated as a non-essential health benefit by Express Scripts, you are eligible for copay assistance provided through the SaveOn SP Program. If you participate in the SaveOn SP Program, you will receive copay assistance in the full amount of the copay owed for your specialty drug prescription. As a result, you will not be required to pay any copay on these designated specialty drugs if you participate in the SaveOn SP Program. However, you will be responsible for the full amount of the copay for a designated specialty drug that is a non-essential health benefit if you do not participate in the SaveOn SP Program, including by complying with all directions and requirements provided

by SaveOn.

For more information about this program or to obtain information about specialty drugs that are on the SaveOn SP Drug list, please visit www.saveonsp.com/santamonicauniteherefunds or contact Express Scripts at (877) 248-1164.

4. Preventive Care Medications and Products

Certain preventive care medications (prescription and over-the counter) and products are covered at 100% if prescribed by a physician or other appropriate health care professional. Preventive care medications and products are available without any copayment, subject to restrictions otherwise applicable (must use generic if available, unless generic alternative is medically inappropriate, mail order pharmacy program requirements for maintenance medications). You must have a prescription in order for your preventive care medication or product to be covered, even if the medication or product is available over-the-counter ("OTC").

Preventive care medications and products are subject to change. Here is partial list of covered products and medications (a written prescription is required for coverage):

- FDA-approved generic contraceptive drugs and devices for women (subject to quantity limits).
- Preparation products for colon cancer screening test.
- Breast cancer prevention drugs - Risk reducing medications such as tamoxifen, soltamox or raloxifene for women 35 years or older with increased risk for breast cancer and at low risk for adverse medication effects.
- Tobacco cessation products - FDA-approved generic tobacco cessation medications (including both prescription and over-the-counter medications) for up to two 90-day treatment regimens per calendar year.
- Statin preventive medication - Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.

Please contact the Administrative Office if you would like information as to whether a specific medication or product is covered under the Plan's preventive care benefits.

5. Cost Sharing Limit for Prescription Drugs

With certain exceptions, your cost sharing for prescriptions filled through Express Scripts is subject to an annual limit.

Specifically, the annual cost sharing limit for Express Scripts is $750 per individual and $1,500 per family. *Cost sharing* includes deductibles, copayments, coinsurance, or similar charges, and any other expenditure for any covered drug. Cost sharing does *not* include premiums or spending for non-covered drugs (such as drugs not purchased from an Express Scripts network or mail order pharmacy), nor does it include the cost difference between a name-brand drug and a generic medication. In addition, effective October 1, 2021, amounts that are owed as copayments with respect to specialty drugs designated as non-essential health benefits by Express Scripts *are not* included in the cost sharing limit for Express Scripts, regardless of whether you participate in the SaveOn SP Program. See Section 3 for more information about designated specialty drugs and the SaveOn SP Program.

The amount of the annual limit may be adjusted annually. You will be notified if the cost sharing limits change in later years.

Covered Items:

- Federal Legend drugs
- State Restricted drugs
- Compounded prescriptions (subject to limitations described below under Special Rules for Compound Drugs)
- Insulin
- Federal Legend Non-Drugs
- Syringes, Needles and Devices
- Accutane, through age 24 only
- Tretinoin, ages 19 through 24 only

6. Special Rules for Compound Drugs:

For compound drugs to be covered under the Plan, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigational, compound drugs must not contain any ingredient on a list of excluded ingredients. That list may be obtained from Express Scripts. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable (e.g. if the cost of any ingredient has increased more than 5% every other week or more than 10% annually, it will not be considered reasonable). Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under the Plan.

7. Special Programs Provided by Express Scripts

The Diabetes Care Value Program. The Diabetes Care Value (DCV) Program is an optional program for qualifying Employees and Dependents. Under this program, the patient is provided with a free Bluetooth-enabled blood glucose meter.

The Pulmonary Care Value Program. The Pulmonary Care Value (PCV) Program is an optional program for qualifying Employees and Dependents. Under this program, the patient is provided with a free Bluetooth-enabled short-acting inhaler that logs the patient's use. There are clinical interventions when overuse is identified.

The Cardiovascular Care Value Program. The Cardiovascular Care Value (CCV) Program is an optional program for qualifying Employees and Dependents to assist with the management of high cholesterol.

The HIV Care Value Program. The HIV Care Value Program is an optional program for qualifying Employees and Dependents to assist with HIV prevention and care.

8. Exclusions

The Prescription Drug Program and the Fund do not pay benefits for the following:

1. Formulary Excluded Drugs (drugs excluded from coverage by Express Scripts).

2. Non-Federal Legend Drugs, Non-Federal Legend Non-Drugs.

3. Over-the-Counter Drugs (except OTC drugs covered as preventive care).

4. Compound drugs that contain any excluded ingredient or are not reasonable in price (See Special Rules for Compound Drugs).

5. Durable Medical Equipment.

6. Hemopoetic Agents.

7. Nicotine Patches (except to the extent covered as preventive care).

8. Abortifacients (including Mifeprex).

9. Accutane (above age 24).

10. Depigmentation Agents.

11. Injectable Cosmetics.

12. Legend Hair Growth Agents.

13. Fertility Regulators.

14. Growth Promoting Agents.

15. Botox.

16. Allergens.

17. Serums, Toxoids, Vaccines.

18. Prescriptions covered without charge under Federal, State, or Local programs, to include Worker's Compensation.

19. Any charge for the administration of a drug or Insulin (these may be covered by your medical plan).

20. Investigational or experimental drugs, except as part of an approved clinical trial.

21. Unauthorized refills.

22. Medication while confined in a hospital, rest home, nursing home, sanitarium, extended care facility, or similar entity.

23. Any item for which the usual and customary charge is less than the copayment under the Plan.

24. Any charge above the usual and customary, advertised, or posted price, whichever is less than the scheduled amount.

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VIII. THE DENTAL CARE PLAN PROVIDED BY UNITED CONCORDIA

The Dental Care Plan is a Dental HMO plan provided by United Concordia. Enrollment in this plan is available to all eligible Employees and their Dependents. You must enroll yourself and your Dependents using United Concordia's enrollment form in order to have dental insurance coverage.

The "Schedule of Benefits," issued by United Concordia, describes covered dental services and procedures and applicable copayments. The Dental Care Plan covers only services and procedures listed on the "Schedule of Benefits," when provided by a participating dental provider identified in the "Concordia Plus DHMO Directory of Participating Dental Providers." **Services and procedures provided by non-participating dental providers are not covered under the Dental Care Plan**. To obtain copies of the "Schedule of Benefits" and the "Concordia Plus DHMO Directory of Participating Dental Providers," please contact the Administrative Office.

In addition to United Concordia's Schedule of Benefits, its Evidence of Coverage and Schedule of Exclusions and Limitations (collectively "Dental Care Plan Documents") provide a complete description of your Dental Care Plan provided by United Concordia. You can obtain a copy of these documents by contacting the Administrative Office or United Concordia. If there is any conflict between any description of the Dental Care Plan benefits contained in this booklet and the description contained in United Concordia's Dental Care Plan Documents, the Dental Care Plan Documents will control.

If you have any questions about your benefits under the Dental Care Plan, please call the United Concordia Customer Service Department toll free at (866) 357-3304, or visit the United Concordia Website: https://www.unitedconcordia.com/dental-insurance/member/.

You may choose to opt out of (or drop) Fund provided dental insurance by contacting the Administrative Office and completing the appropriate form.

IX. THE DELTA DENTAL PPO PLAN

The Delta Dental PPO Plan is an insured dental plan provided by Delta Dental. Enrollment in this plan is available for all eligible Employees and their Dependents who meet the requirements shown in Section 3.B. of Article III.

A summary of your benefits under the Delta Dental PPO Plan is available in a "Plan Benefits Highlights," issued by Delta Dental. For a copy, please contact the Administrative Office.

Under the Delta Dental PPO Plan, you can visit any licensed dentist. **However, your out-of-pocket costs will be less if you go to a Delta Dental PPO dentist.** Delta Dental PPO dentists have agreed to charge lower rates and can't balance bill you for additional fees. You can find a Delta Dental PPO dentist by visiting deltadentalins.com or by calling (800) 765-6003.

Detailed information on covered benefits and other rules for the Delta Dental PPO Plan are described in Delta Dental's "Combined Evidence of Coverage and Disclosure Form" for the Santa Monica UNITE-HERE Health Benefit Fund. This Combined Evidence of Coverage and Disclosure Form and the Delta Dental PPO^{SM} Group Dental Service Contract between the Fund and Delta Dental of California (collectively "Delta Dental Plan Documents") provide a complete description of benefits under the Delta Dental PPO Plan. If there is any conflict between any description of the Delta Dental PPO Plan benefits contained in this booklet and the description contained in the Delta Dental Plan Documents, the Delta Dental Plan Documents will control.

You can obtain a copy of these documents by contacting the Administrative Office or by calling Delta Dental's Customer Service Department.

If you have any questions about your benefits under the Delta Dental PPO Plan, please call the Delta Dental Customer Service Department toll free at (800) 765-6003, or visit the Delta Dental Website at deltadentalins.com.

You may choose to opt out (or drop) Fund provided dental insurance coverage by contacting the Administrative Office and completing the appropriate form.

X. THE VISION SERVICE PLAN (VSP) BENEFIT PROVIDED BY VISION SERVICE PLAN, INC.

IMPORTANT (PLEASE READ): This brief description of the Vision Service Plan Benefit (the "VSP Benefit") is included in this booklet for your convenience. This booklet does not contain a complete description of the VSP Benefit. *For detailed information about the VSP Benefit, please refer to the Evidence of Coverage ("EOC"), available by calling the Administrative Office. If there is a conflict between any description of the VSP Benefit contained in this booklet and VSP's EOC or the Fund's contract with VSP, the EOC or the contract with VSP will control. Please call VSP at the telephone number listed on the Reference Chart at the front of this booklet for a detailed benefit summary or call the Administrative Office for a copy of the EOC.*

The Vision Service Plan Benefit (the "VSP Benefit") will provide benefits for frames and lenses (or contacts) as described in this section. In order to have this coverage, you must be enrolled for medical coverage under one of the Fund's medical plans.

To use this benefit, you must first have a vision exam and get a prescription for eyeglasses or contact lenses.

If you are in one of the HMO Plans (Kaiser or Health Net): you must obtain your vision exam through your HMO. You will then bring your vision prescription to any VSP network doctor to obtain glasses or contact lenses.

If you are in the MLK Program: you will obtain your vision exam from a VSP doctor at no charge. If you use a provider who is not a VSP doctor, VSP will reimburse you up to $45.00 for your eye exam. The VSP Benefit provides one eye exam every 12 months.

Below is a chart that summarizes the benefits available if you use a VSP network doctor.

The VSP Benefit provides out-of-network benefits. However, if you use an out-of-network provider (i.e., a doctor that is not contracted with VSP), benefits will be limited, and you will need to call VSP or the Administrative Office for information about benefits.

VSP has an extensive network of doctors throughout the United States. For a list of VSP doctors, call VSP at (800) 877-7195 or visit their website at vsp.com.

Once you have located a VSP doctor, you can call the doctor's office directly in order to make an appointment. There are no ID cards necessary or claim forms to complete when using a VSP doctor; simply inform the doctor that you're a VSP member.

With the VSP Benefit, lenses and frames are provided as follows:

Eyeglass Lenses:	Every 24 months
Frames:	Every 24 months

An allowance for contact lenses is available every 24 months in lieu of glasses.

In addition, if you are in the MLK Program, vision exams are provided as follows:

Vision Exam:	Every 12 months (only for Participants in the MLK Program).

IN-NETWORK BENEFITS (Using a VSP Contracted Provider)	
Benefit	**Participant Cost**
Exam (for Participants in the Health Net or Kaiser HMO)	Not Covered. (Covered through your Fund provided HMO plan (Health Net or Kaiser).
Exam (for Participants in the MLK Program)	$0 copay (Limited to one exam every 12 months).
Standard Plastic Lenses: Single vision Bifocal Trifocal	 $0 copay $0 copay $0 copay Options such as UV coating, tint, anti-reflective coating and polycarbonate lenses are available for an additional charge.
Standard Progressive Lenses	$0 copay
Premium Progressive Lenses	Premium: $95-$105 Custom: $150-$175
Lens Options: UV Coating	 $10-$16 copay
Tint (solid and gradient)	$0 copay
Standard Polycarbonate	$31 copay ($35 if multifocal lens)
Standard Anti-Reflective Coating	$41 copay
Other Add-Ons	Most lens enhancements are covered with fixed copays, saving participants an average of 25%. All other lens enhancements receive a 20% discount.
Frames: Basic	 Participant pays 80% of cost above $120 allowance
Featured Brands	Participant pays 80% of cost above $140 allowance
Contact Lenses: *Coverage for contact lenses is in lieu of benefits available for glasses.* Conventional or Disposable	 Participant pays 100% of cost above $120 allowance for lenses available every 24 months. Up to $60 copay for contact lenses fitting exam.
Medically Necessary Contact Lenses (as determined by VSP)	$0 copay
Laser Vision Correction: Lasik or PRK	 Participant pays 85% of retail cost
Additional Pairs of Glasses	Participant pays 80% of retail cost

The VSP Benefit is automatically included if you enroll for medical coverage under one of the Fund's medical plans. You may choose to opt out of the VSP Benefit by contacting the Administrative Office and completing the appropriate form. You will get no advantage by opting out of VSP coverage.

XI. THE MEMBER ASSISTANCE PROGRAM (MAP) PROVIDED BY BEACON HEALTH OPTIONS

Telephone: (888) 479-6606

The Member Assistance Program (the "MAP"), administered by Beacon Health Options, Inc ("Beacon"), provides information, guidance, and support to help you and your family reach your personal and professional goals, manage daily stresses, and develop fulfilling relationships. In addition to this brief description of the MAP, a separate pamphlet prepared by Beacon is available from the Administrative Office.

The MAP provides you and each of your enrolled Dependents three (3) free and confidential visits per year (whether in person or via telephone or video) for confidential* counseling, consulting, and referral services in a broad range of areas, such as:

- Work problems
- Family problems
- Stress
- Parenting problems
- Problems with supervisors
- Self-esteem
- Anxiety
- Fatigue
- Divorce and separation
- Physical abuse
- Communication difficulties
- Depression
- Aging parents
- Life changes
- Illness or disability

MAP provides confidential assessment and help for chemical dependency problems and assistance in finding treatment. In addition, MAP offers a variety of counseling in areas such as job stress, handling conflict, dealing with change, dealing with difficult customers, assertiveness, job uncertainty, communication skills, team building, or alcohol and drug awareness.

MAP services are completely voluntary and confidential.* Nothing you say is discussed without your specific permission. The MAP is administered by:

Beacon Health Options, Inc.
P.O. Box 6065
Cypress, California 90630-0065
(888) 479-6606

To access MAP services or if you have questions about the MAP, call Beacon at (888) 479-6606 (24 hours a day, 7 days a week) or visit www.achievesolutions.net/santamonicauhh.

** Patient's statements may not be held private if the patient is dangerous to self or others or describes child or elder abuse.*

XII. LIFE INSURANCE BENEFITS

Life Insurance benefits are provided directly by the Fund in the amount of $20,000.

When proof of your death is received by the Administrative Office, the Life Insurance benefit will be paid to your beneficiary, in accordance with this Article XII. When proof of your Dependent's death is received by the Administrative Office, the Life Insurance benefit will be paid to you (the Employee).

Only eligible Employees and their Dependents, as defined in Article I, are covered for Life Insurance benefits. Life Insurance coverage ends when eligibility ends under Article II, except that eligibility for Life Insurance does not continue during periods of extended eligibility due to disability under Article II, Section 8, or during COBRA continuation coverage.

9. Beneficiary for Employee Life Insurance

You may designate one or more beneficiaries to receive the Life Insurance benefit upon your death, or change any beneficiary designation, at any time, by submitting a written beneficiary designation notice to the Administrative Office using a form approved by the Fund. Any designation or change will take effect after it has been received by the Administrative Office, provided benefits have not been paid before it was received. Additionally any designation or change of beneficiary must be received by the Administrative Office before your death to be effective.

If you designate more than one beneficiary, but do not state amounts or order of payment, benefits will be equally divided among your designated beneficiaries.

If you designate more than one beneficiary and one dies before you, his or her share will go equally to your surviving beneficiaries, or to the sole surviving beneficiary.

If you have no designated beneficiary at the time of your death, or if your designated beneficiaries all predecease you, benefits will be paid to the member(s) of the first surviving class as follows:

1. Your legal spouse or Domestic Partner;
2. Your children and the covered children of your enrolled Domestic Partner;
3. Your parents;
4. Your brothers and sisters;
5. Your estate

If there are no beneficiaries, up to $1,000 of the benefits may be paid to anyone who pays expenses for your final illness or funeral. Any payment that the Plan makes in good faith under these provisions will discharge the Plan's liability to the extent of the payment.

XIII. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Accidental Death & Dismemberment benefits are provided directly by the Fund. Only eligible Employees, as defined under Article I, are covered for Accidental Death & Dismemberment benefits. Accidental Death & Dismemberment benefits are not available for the accidental death or injury of a Dependent.

Accidental Death & Dismemberment coverage ends when eligibility ends under Article II, except that eligibility for Accidental Death & Dismemberment benefits does not continue during periods of extended eligibility due to disability under Article II, Section 8, or while you are covered under COBRA.

When proof of your accidental death is received by the Administrative Office, and your accidental death occurs within 90 days after and as a direct result of an accident, the Accidental Death and Dismemberment benefit for loss of life is paid to your named beneficiary. You may name or change any beneficiary at any time by filing a written notice with the Administrative Office using a form approved by the Fund. The beneficiary rules set forth in Article XII, under "Beneficiary for Employee Life Insurance," apply to payment of the Accidental Death benefit.

When, within 90 days after and as a direct result of an accidental injury, you sustain one of the losses listed below (other than loss of life), and proof of such loss is received by the Administrative Office, a dismemberment benefit will be paid to you.

For the loss of the following, a $10,000 benefit will be paid:

1. Life
2. Both hands or both feet
3. Sight of both eyes
4. One hand and one foot
5. One hand and sight of one eye
6. One foot and sight of one eye

For the loss of the following, a $5,000 benefit will be paid:

1. One hand or one foot
2. Sight of one eye

Only one benefit, in the greater of the amounts payable, will be paid as a result of all injuries or losses sustained in or as the result of any one accident. All claims must be received within one year of death or accidental injury or benefits will not be payable.

Loss means, with respect to hands and feet, the actual severance at or above the wrist or ankle joint, and with respect to eyes, the entire and irrecoverable loss of sight.

Accidental death means death resulting from an external, violent and unexpected means and includes death by homicide.

Accidental injury means bodily injury resulting from an external, violent and unexpected means.

5. Exclusions

This Accidental Death & Dismemberment Benefit does not cover the following:

1. Loss caused by war or any act of war.

2. Loss occurring during air travel.

3. Loss caused by suicide or any attempt at suicide.

4. Loss which occurs while the covered person is committing a felony.

5. Loss due to disease or bacterial infection (except pus-forming infection occurring with an accidental wound)

6. Loss due to diabetes or any sickness attributable to diabetes.

7. Loss due to injection, inhalation, or ingestion of any substance for purposes other than those prescribed by a doctor.

XIV. EXTENDED COVERAGE (FOR MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION, AND MAP BENEFITS)

C. Extension of Coverage Under COBRA

In accordance with a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), each "qualified beneficiary" will be entitled to COBRA coverage, which is a temporary extension of health coverage under the Plan at group rates when such coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are shown in the chart below.

After a qualifying event occurs, and any required notice of that event is timely provided to the Administrative Office, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." Depending on the qualifying event, qualified beneficiaries can include the covered Employee, the Employee's covered spouse or Domestic Partner, and the Employee's covered children. **COBRA coverage is not provided free of charge; qualified beneficiaries who elect COBRA coverage must pay for it.**

COBRA coverage is the same health coverage that the Plan gives to covered Employees and Dependents who are not receiving COBRA, but it does not include Life Insurance or Accidental Death and Dismemberment benefits. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as Employees and Dependents with active medical coverage under the Plan, including Open Enrollment and Special Enrollment rights. **However, qualified beneficiaries do not have coverage for Life Insurance or Accidental Death and Dismemberment benefits during a period of COBRA coverage**.

The chart below shows all of the qualifying events that can occur under this Plan. It also shows the qualified beneficiaries who are entitled to elect COBRA, as well as the maximum COBRA coverage period, for each type of qualifying event.

Qualifying Event	Qualified Beneficiary (if covered under Plan)	Maximum COBRA Coverage Period
1. Reduction in covered Employee's hours of employment	Employee, spouse/Domestic Partner, and children	18 months from the date Plan coverage is lost due to the qualifying event
2. Termination of covered Employee's employment (for reasons other than the Employee's gross misconduct)	Employee, spouse/Domestic Partner, and children	18 months from the date Plan coverage is lost due to the qualifying event
3. Death of covered Employee	Spouse/Domestic Partner and children	36 months from the date Plan coverage is lost due to the qualifying event
4. Divorce from covered Employee or cessation of Domestic Partnership status under the Plan	Spouse/Domestic Partner and children	36 months from the date Plan coverage is lost due to the qualifying event
5. Loss of child status under Plan (such as if the child turns 26)	Affected child	36 months from the date Plan coverage is lost due to the qualifying event

A. How Extended Active Coverage Affects COBRA Coverage

The 18-, 29-, or 36-month maximum COBRA coverage period will not be reduced by months of free or subsidized coverage provided by the Plan in the event of disability (see Article II, Section 8).

B. Alternative To COBRA: Marketplace Coverage

In addition to COBRA coverage from the Plan, you and your family members may have health insurance options under the Affordable Care Act available through the Health Insurance Marketplace (also known as the Exchange). Buying health insurance coverage from the Marketplace is an alternative to COBRA coverage.

- Health insurance coverage purchased through the Marketplace may cost less than COBRA coverage, and there may be more coverage options available to you. Marketplace coverage may provide lower or higher benefits than COBRA coverage. Be sure to compare benefits and premiums.

- In the Marketplace, you could be eligible for tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being offered COBRA coverage won't limit your eligibility for a tax credit through the Marketplace, though you will not be eligible for coverage or tax credits in the Marketplace while you are enrolled in COBRA (see next bullet point for information on enrolling in Marketplace coverage after electing COBRA coverage).

- Generally, you must enroll in Marketplace coverage within 60 days of your loss of Plan coverage or during a Marketplace annual open enrollment period. If you enroll in COBRA, you may not enroll in Marketplace coverage until the next Marketplace annual open enrollment period, or upon the exhaustion of your COBRA coverage (i.e., after the end of your maximum COBRA coverage period of 18, 29 or 36 months), or if you have a qualifying event such as marriage or birth of a child through something called a "special enrollment period."

- Preexisting condition exclusions are prohibited under the Affordable Care Act for COBRA and Marketplace coverage.

For more information about health insurance options available through a Health Insurance Marketplace in California, or to apply for coverage, go to www.coveredca.com or call (800) 300-1506.

If you live outside of California, more information about health insurance options is available at www.healthcare.gov or call (800) 318-2596.

C. Notification Requirements

The Plan will offer COBRA coverage to each qualified beneficiary only after the Administrative Office has been timely notified that a qualifying event has occurred.

Your Obligation to Notify the Administrative Office: You or your Dependents are responsible for notifying the Administrative Office of a qualifying event that is divorce, legal separation, cessation of Domestic Partnership status, or loss of child status. Notice must be written and given within 60 days after the date Plan coverage is lost due to the qualifying event. Your written notice must contain the following information: (i) the name of the Plan; (ii) the Employee's name; (iii) the name(s) of the Employee's Dependent(s); (iv) the address(es) and telephone number(s) of the Employee and his or her Dependent(s); and (v) the date and nature of the qualifying event. The Administrative Office may also require that supporting documentation be submitted, such as a divorce decree. **If the required notice is not timely submitted to the Administrative Office, you and/or your Dependents will lose the right to elect COBRA coverage.**

You or your Dependents are also responsible for notifying the Administrative Office in writing of a second qualifying event, disability determination, or end of disability (explained in more detail below under "Extensions of COBRA Coverage").

Finally, you should notify the Administrative Office of your retirement or a change in address for you or a Dependent, as well as changes in marital or Domestic Partnership status. You should keep copies, for your records, of any notices you send to the Administrative Office.

Employer's Obligation to Notify the Administrative Office: Your Employer is responsible for informing the Administrative Office of an Employee's death. Your Employer is also required to submit monthly reports of Hours Worked to the Administrative Office, which will enable the Administrative Office to determine whether a qualifying event that is the termination of employment or reduction in hours of employment has occurred. However, to ensure that you are timely notified of your COBRA rights, you or your Dependent should also notify the Administrative Office promptly and in writing if any of these events occur in order to avoid confusion over the status of your health care coverage in the event there is a delay or oversight in the Employer's transmittal of information to the Administrative Office.

D. Electing COBRA Coverage

Within 45 days after the Administrative Office receives timely notice of a qualifying event, it will provide a COBRA election notice and election form to affected qualified beneficiaries. This notice will contain detailed information concerning COBRA coverage and its cost.

Each qualified beneficiary will be offered a choice between a Core-Only plan of benefits (medical, prescription drug, and MAP) and a Core-Plus plan of benefits (Core-Only plus dental and vision) . All qualified beneficiaries in one family unit are not required to elect the same plan of COBRA benefits (Core-Only or Core-Plus). However, all family members must be in the same medical plan (Health Net or Kaiser) under which they were eligible on the day before the occurrence of the qualifying event.

Each qualified beneficiary is allowed to change medical plans on the same basis as Employees and Dependents with active Plan coverage (e.g., during Open Enrollment). COBRA coverage does not include Life Insurance or Accidental Death & Dismemberment benefits.

To elect COBRA coverage, you or your Dependent must complete the election form and submit it to the Administrative Office according to the directions on the form and within 60 days after the later of:

1. The date coverage under the Plan is lost because of the qualifying event, or
2. The date the Administrative Office mails the election notice.

An election is considered to be made on the date the completed and signed election form is mailed to the Administrative Office. If COBRA coverage is not elected within this 60-day election period, the right to elect COBRA coverage will be lost.

If a qualified beneficiary rejects COBRA coverage before the date the election form is due, (s)he may change his/her mind as long as (s)he sends the completed and signed election form to the Administrative Office before the due date. However, if a qualified beneficiary changes his/her mind after first rejecting COBRA coverage, his/her COBRA coverage will begin on the date the completed and signed election form is sent to the Administrative Office.

Each qualified beneficiary has an independent (i.e., separate) right to elect COBRA coverage. For example, your spouse or Domestic Partner may elect COBRA, even if you do not. COBRA coverage may be elected for only one, several, or for all Dependent children who are qualified beneficiaries. You may elect COBRA coverage on behalf of your spouse/Domestic Partner, and parents may elect COBRA coverage on behalf of their children.

In considering whether to elect COBRA coverage, you should take into account that you may have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's or Domestic Partner's employer) within 30 days after your Fund coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

If the Administrative Office receives a notice relating to a qualifying event or disability determination regarding an Employee/former Employee, spouse/Domestic Partner, Dependent child, or other person, and it determines that such person is not entitled to COBRA coverage, the Administrative Office will provide to such person a written denial notice containing the reason for the denial.

E. Adding Dependents to COBRA Coverage

A child who is born to, adopted by, or placed for adoption with the Employee during a period of COBRA coverage becomes a qualified beneficiary entitled to COBRA in his or her own right.

In contrast, a new spouse/Domestic Partner or a child who is not a newborn or new adoptee of the Employee can be added to COBRA coverage, but is not a qualified beneficiary with independent COBRA rights. If the Employee's COBRA coverage ends for any reason, the new spouse/Domestic Partner or Dependent child's COBRA coverage will end too.

In order to add a Dependent to COBRA coverage, the COBRA enrollee must notify the Administrative Office in writing within thirty (30) days of birth, adoption, marriage, registration of Domestic Partnership, or other event leading to the acquisition of the new Dependent. You may be required to submit written proof of dependency to the Administrative Office.

F. Payment Requirements

Each qualified beneficiary must pay the full cost of COBRA coverage by paying a monthly premium to the Administrative Office. As provided under federal law, monthly COBRA premiums will be 102% (or 150% in the case of an extension of COBRA coverage due to a disability) of the cost of group coverage for active Employees.

The first COBRA premium payment must be postmarked within forty-five (45) days of the date the COBRA election was made (this is the date the completed and signed COBRA election form is post-marked, if mailed to the Administrative Office). The first COBRA payment must include any months retroactive to the date Plan coverage terminated. You are responsible for making sure that the amount of the first payment is correct. You may contact the Administrative Office to confirm the correct amount of the first payment. COBRA coverage will not be effective until the first payment is received.

Subsequent premium payments must be made on a monthly basis and are due on the first day of each month for which COBRA coverage is desired (e.g., payment is due on January 1st for COBRA coverage in January). If a monthly payment is made on or before the first day of the month to which it applies, COBRA coverage will continue for that month without any break. The Administrative Office will not send monthly bills or warning notices of payments due for these coverage periods. It is the responsibility of you or your Dependents to send the required payments when due.

There is a 31-day grace period to make each monthly COBRA payment. That means that each monthly COBRA payment must be postmarked within thirty-one (31) days after the due date. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period. However, if you pay a monthly COBRA payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your COBRA coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All payments for COBRA coverage must be in the form of a personal check, cashier's check, or money order payable to the Santa Monica UNITE HERE Health Benefit Trust Fund and remitted to the Administrative Office.

No benefit claim will be honored unless the required premium payment for the period in which the claim was incurred is timely sent. Please note that if any health care provider, such as a doctor or pharmacy, inquiries about your eligibility, the Plan is required by law to make a complete disclosure of whether or not the COBRA election period has expired, or whether COBRA has been elected but not yet paid for.

If payment for COBRA coverage is not timely made in full, you will lose all rights to COBRA coverage under the Plan as of the end of the last month for which a COBRA payment was properly made.

G. Extensions of COBRA Coverage

There are three ways in which a maximum COBRA coverage period of 18 months can be extended.

Entitlement to Medicare: When the qualifying event is the termination of employment or reduction in hours, and the Employee became entitled to Medicare less than 18 months before the qualifying event, the maximum COBRA coverage period for qualified

beneficiaries other than the Employee is 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse/Domestic Partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability: If, during an 18-month maximum COBRA coverage period, a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled, the qualified beneficiary (and his/her family members who have also elected COBRA) may be entitled to receive up to an additional 11 months of COBRA coverage, for a maximum of 29 months. The disability has to have started at some time before the 60th day of COBRA coverage and must last at least until the end of the initial 18-month period of COBRA coverage. COBRA premiums during this disability extension period will increase to 150% of the cost of group coverage. In order to qualify for this extension, you or your Dependent must notify the Administrative Office in writing of the SSA's determination within 60 days after the date of the SSA determination (or if the qualified beneficiary is already disabled, within 60 days after the date coverage is lost due to the qualifying event), but before the end of the initial 18-month maximum COBRA coverage period. This written notice must include the following information: (i) the name of the Plan; (ii) the Employee's name; (iii) the name(s) of the Employee's Dependent(s); (iv) the address(es) and telephone number(s) of the Employee and his or her Dependent(s); (v) the date of the SSA's disability determination; and (vi) a copy of the SSA determination letter. This disability extension will terminate if the SSA makes a final determination that the qualified beneficiary is no longer disabled before the end of the 11-month disability extension period. If this is the case, you or your Dependent must notify the Administrative Office in writing within 30 days after the date of the final SSA determination that the qualified beneficiary is no longer disabled. The notice must contain the information listed in the above paragraph.

Second Qualifying Event: If, during an 18-month maximum COBRA coverage period, a second qualifying event occurs that is the former Employee's death, divorce or legal separation, cessation of Domestic Partnership status, or loss of Dependent child status under the Plan, COBRA coverage for the affected spouse, Domestic Partner, and/or child may be extended up to 36 months. These events can be a second qualifying event only if they would have caused the spouse/Domestic Partner or child to lose Plan coverage if the first qualifying event had not occurred. In order to qualify for this extension, you or your Dependent must notify the Administrative Office in writing of the second qualifying event within 60 days after the date of such event. This written notice must include the following information: (i) the name of the Plan; (ii) the Employee's name; (iii) the name(s) of the Employee's Dependent(s); (iv) the address(es) and telephone number(s) of the Employee and his or her Dependent(s); and (v) the date and nature of the qualifying event. The Administrative Office may also require that supporting documentation be submitted, such as a divorce decree.

H. Early Termination of COBRA Coverage

COBRA coverage will end before the 18-, 29-, or 36-month maximum COBRA coverage period expires if any of the following events occur:

1. The required payment for COBRA coverage is not timely remitted to the Administrative Office (i.e., the full amount is not postmarked by the 31st day after the payment due date).

2. A qualified beneficiary becomes covered, after electing COBRA, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans' imposing a pre-existing condition exclusion and such exclusions generally became prohibited beginning in 2014 under the Affordable Care Act).

3. A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA coverage (COBRA coverage for any family member who is not covered by Medicare will not be affected).

4. The Employee's Employer ceases to contribute to the Fund, but provides other group health plan coverage for its employees.

5. The Social Security Administration (SSA) determines that a qualified beneficiary is no longer disabled. You must inform the Administrative Office within 30 days of such SSA determination, in which case the extended COBRA coverage period will terminate for all qualified beneficiaries whose extended coverage derived from the disability at the end of the month in which the SSA makes its determination.

6. This Plan terminates.

Also, COBRA coverage may be terminated for any reason the Plan would terminate coverage of an Employee or Dependent not receiving COBRA coverage (such as fraud).

Once COBRA coverage ends for any reason, it cannot be reinstated. Furthermore, any claims incurred after the COBRA coverage termination date will not be paid by the Plan.

If COBRA coverage is terminated before the expiration of the 18-, 29-, or 36-month maximum COBRA coverage period, the Administrative Office will send the affected qualified beneficiary a written termination notice as soon as reasonably practicable after it determines that the COBRA coverage will end. Such notice will contain the following: (i) the reason for early termination; (ii) the termination date; and (iii) any rights the qualified beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage, such as a conversion right.

D. Extension of Coverage Under Cal-COBRA

The California Continuation Benefits Replacement Act ("Cal-COBRA") supplements federal COBRA by requiring HMOs to offer an extension of group health plan coverage for up to 18 months under certain circumstances. This means that you may be able to receive up to 36 months of continued coverage from the date your federal COBRA coverage first started.

This Cal-COBRA extension is only available to COBRA enrollees who:

- Began receiving federal COBRA coverage on or after January 1, 2003;
- Have a maximum federal COBRA coverage period of less than 36 months; and
- Have exhausted such federal COBRA coverage.

Cal-COBRA coverage only includes medical and hospital benefits. Also, Cal-COBRA coverage is subject to payment of premiums directly to the HMO plan in which you are enrolled and can cost up to 110% (150% for the disability extension) of the applicable group rate. You must contact Health Net or Kaiser for the premium required to continue your coverage under Cal-COBRA. All other terms and conditions that apply to federal COBRA coverage apply to Cal-COBRA coverage.

Cal-COBRA coverage will not be available if your federal COBRA coverage terminates before the end of the 18- or 29-month maximum COBRA coverage period or if you and/or your spouse or former spouse were eligible but did not elect federal COBRA. You must elect Cal-COBRA coverage by notifying Health Net or Kaiser in writing within 30 calendar days prior to the date your federal COBRA coverage is scheduled to end.

Please refer to the Health Net or Kaiser Evidence of Coverage booklet for more information regarding Cal-COBRA, including detailed information on what you must do to enroll for this special extension. If you have any questions about Cal-COBRA coverage, please contact Health Net or Kaiser directly.

E. Medical Conversion

When extended coverage (either COBRA or Cal-COBRA) has been exhausted, you and/or your covered Dependents may be entitled to convert from the Fund's group HMO plan to an individual conversion policy with your HMO as set forth in the medical conversion provision of the group policy. If you want this conversion coverage, contact Health Net or Kaiser immediately after the termination of your continued coverage, as you only have a limited time to apply for it.

You and your family members may also have options available under the Affordable Care Act through the Health Insurance Marketplace (also known as the Exchange). Generally, you can only enroll in Marketplace coverage: (1) within 60 days after your loss of Plan coverage (including exhaustion of COBRA or Cal-COBRA); (2) during a Marketplace annual open enrollment period; or (3) if you qualify for a Special Enrollment Period due to a life event such as marriage or the birth of a child. For more information about health insurance options available through a Health Insurance Marketplace in California, or to apply for coverage, go to www.coveredca.com or call (800) 300-1506. If you live outside of California, more information about health insurance options is available at www.healthcare.gov or call (800) 318-2596.

XV. OTHER RIGHTS AND OBLIGATIONS UNDER THE PLAN

F. Family Medical Leave Act (FMLA)

The federal Family and Medical Leave Act ("FMLA") generally requires covered employers to permit eligible employees to take up to 12 weeks of unpaid, job-protected leave each year (26 weeks in certain circumstances). The leave may be taken for one of several reasons that are specified by law. Details concerning FMLA leave are available from your Employer. Requests for FMLA leave must be directed to your Employer; the Administrative Office cannot determine whether or not you qualify.

To the extent required by the FMLA, your Employer must continue to pay for your health coverage under the Plan during any approved FMLA leave. If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your share of the premiums), you may resume your coverage upon return from leave on the same terms that applied before the leave was taken.

You will not be entitled to COBRA coverage simply by taking an FMLA leave. However, if you do not return to work after taking an FMLA leave, you may have COBRA rights, even if you decline to continue your health coverage under the Plan or fail to pay the premium for such coverage during the leave.

If a dispute arises between you and your Employer concerning your eligibility for FMLA leave, you will be permitted to continue your health coverage under COBRA. If the dispute is resolved in your favor, the Administrative Office will obtain the FMLA-required contributions from your Employer and will refund any corresponding COBRA premium payments to you. If your Employer continues your coverage under the Plan during an FMLA leave and you fail to return to work, you may be required to repay the Employer for all contributions paid to the Plan for your health coverage during the leave.

G. Military Service (USERRA)

Under a federal law called the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), covered Employees can pay for a temporary extension of health coverage under the Plan at group rates for themselves and their covered Dependents if they would otherwise lose such coverage due to the Employee's service in the uniformed services.

This extension of coverage ("USERRA coverage") can last up to 24 months, beginning on the date of the Employee's absence from employment to perform uniform services.

A person electing USERRA coverage may be required to pay for all or part of the cost of such coverage. If you perform service in the uniformed services for fewer than 31 days, you will pay the same amount for the coverage that you normally pay. If your service exceeds 30 days, the amount charged cannot exceed 102% of the cost to the Plan of providing the coverage.

USERRA coverage may terminate before the expiration of the 24-month coverage period if:

1. The Employee fails to pay required premiums on time.

2. The Employee fails to report back to work or apply for reemployment in a timely manner following the completion of uniformed service.

3. The Employee loses USERRA rights as a result of certain types of conduct, including court-martial and dishonorable discharge.

4. The Employer no longer provides group health coverage to any of its employees.

Covered Employees have the right to have their health coverage under the Plan reinstated in accordance with USERRA if: (1) such coverage was terminated as a result of uniformed service; (2) the Employees are reemployed following completion of such service within the timeframes required by USERRA; and (3) other requirements of USERRA are satisfied.

For more information about USERRA coverage, including how to elect such coverage and payment amounts and deadlines, contact the Administrative Office.

H. Working Employees and Dependents Eligible for Medicare (Dental, Life Insurance, and Accidental Death & Dismemberment Benefits Not Affected)

Medicare beneficiaries may choose to retain or drop medical coverage, including prescription drug benefits, under this Plan.

- If you or one of your Dependents choose to retain your Plan coverage, your Fund coverage will generally be primary and will continue to provide you the same coverage provided to other active Employees and their covered Dependents. Medicare may then provide additional or secondary coverage.

- If you or a Medicare Eligible Dependent wants Medicare to be primary, you or your Dependent may choose to drop your Fund medical coverage, and Medicare will be primary. However, if you make this choice, you will not have any medical coverage (including vision and prescription drug benefits) from this Plan. The only coverage you can retain from this Plan is Life Insurance, AD&D Benefits, and Dental insurance.

The choice of retaining or dropping Plan medical coverage is solely your responsibility. Neither the Fund nor your Employer will provide any consideration, incentive, or benefits to encourage dropping Plan coverage. If you are the covered Employee, and you drop your medical coverage under the Plan, your Dependents will also lose their medical coverage under the Plan.

Note: Voluntarily dropping Plan coverage is not a COBRA qualifying event. Therefore, if a Medicare beneficiary voluntarily drops his or her Plan coverage (for instance, during Open Enrollment), he or she will not be entitled to COBRA Coverage, since choosing to drop Plan coverage is not a COBRA Qualifying Event.

IF YOU WANT MEDICARE AS YOUR PRIMARY COVERAGE, YOU MUST SUBMIT A WRITTEN STATEMENT TO THE PLAN REJECTING YOUR COVERAGE UNDER THE PLAN IN FAVOR OF MEDICARE. UNDERSTAND THAT YOU WILL GET NO ADVANTAGE FROM THE FUND FOR MAKING THIS DECISION.

I. Qualified Medical Child Support Orders (QMCSOs)

Federal law requires the Plan, under certain circumstances, to honor the terms of a Qualified Medical Child Support Order ("QMCSO") providing continued health care coverage for your Dependent children. A QMCSO is an order, decree, judgment, or administrative notice (including a settlement agreement) issued by a court of competent jurisdiction, or by an administrative agency authorized to issue child support orders under state law, which meets the requirements of Section 609 of ERISA.

If the Administrative Office receives a QMCSO, the child(ren) identified in the QMCSO will be enrolled in the Plan as your Dependent(s), provided that they are otherwise eligible for coverage under the Plan. The child's custodial parent, legal guardian, or a state agency can make application for Plan coverage, even if you do not.

Any payment for benefits made by the Plan under the QMCSO as reimbursement for expenses paid by either the child or the child's custodial parent or legal guardian must be paid to the alternate recipient or that child's custodial parent or legal guardian. Any such payments made to the custodial parent or the legal guardian or to an official of a State or its political subdivision (whose name and address are used for the address of an alternate recipient) will be treated as payment of benefits to the alternate recipient.

If you have any questions about any of these requirements, contact the Administrative Office.

J. Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, coinsurance and copayments applicable to other medical and surgical benefits provided under the Plan. If you would like more information on WHCRA benefits, call your HMO or the Administrative Office.

K. Hospital Stay Following Childbirth

Under the Newborns' and Mothers' Health Protection Act of 1996, benefits may not be restricted for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

L. Notice of Patient Protections and Choice of Providers (Health Net)

For Health Net Plan Enrollees who live in California: The Health Net Plan generally requires the designation of a Primary Care Physician ("PCP"). You have the right to designate any PCP who participates in the Salud HMO y Mas network and who is available to accept you or your family members. Until you make this designation, Health Net designates one for you. For information on how to select a PCP, and for a list of the participating Primary Care Physicians, call Health Net at (800) 522-0088 or you may call the number shown on the back of your Health Net I.D. Card. You can also visit the Health Net website at www.healthnet.com.

For children, you may designate a pediatrician as the PCP.

You do not need prior authorization from Health Net or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Salud HMO y Mas network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call Health Net at (800) 522-0088 or call the number on the back of your Health Net I.D. Card.

For Health Net Plan enrollees who live in Mexico: Health Net enrollees who live in Mexico do not need to select a PCP and can visit any provider in the SIMNSA network.

M. Notice of Patient Protections and Choice of Providers (Kaiser)

For Kaiser Permanente Enrollees: Personal physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

Kaiser Permanente encourages you to choose a personal physician. You may choose any available personal physician. Parents may choose a pediatrician as the personal physician for their child. Most personal physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal physicians.

To learn how to select a personal physician, please refer to the Getting Started brochure, Your Guidebook, or call Kaiser's Member Service Call Center. You can find a directory of plan physicians on Kaiser's website at kp.org. For the current list of physicians that are available as personal physicians, please call the personal physician selection department at the phone number listed in the Getting Started brochure or in Your Guidebook. You can change your personal physician for any reason.

You do not need a referral or prior authorization from any person (including a personal physician) in order to obtain access to obstetrical or gynecological care from an in-network Kaiser health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Please see your Evidence of Coverage for more information.

N. Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

XVI. CLAIMS AND APPEALS PROCEDURES

For purposes of these Claims and Appeals Procedures, the term "you" or "yours" refers to any covered Participant in the Plan (i.e., covered Employees and covered Dependents).

O. Applicability

A. These claims and appeals procedures apply to the following:

- Claims and appeals for Life Insurance and Accidental Death & Dismemberment benefits provided by the Plan.
- Disputes concerning eligibility determinations that are unrelated to any specific Claim for a Plan benefit and that are not rescissions, including appeals regarding eligibility for coverage under the Plan (including COBRA coverage).
- Disputes concerning rescissions of Plan coverage that are unrelated to any specific Claim for a Plan benefit.
- Claims denials involving a determination of disability under Article II, Section 8 of this SPD (for "Extended Eligibility for Disability Credit").

B. These procedures do **not** apply to medical benefits provided by the Fund under the MLK Program. All claims, appeals, voluntary second-level review requests, and external review requests with respect to medical benefits provided under the MLK Program must be submitted to Design Benefits Administrators (DBA) and will be processed in accordance with the MLK Program's claims and appeals procedures, which are set forth in Article IV of this booklet.

C. These procedures also do **not** apply to the following benefits:

- Medical benefits provided through the Health Net or Kaiser HMO plans
- Medical benefits provided through the MLK Program
- Prescription Drug benefits provided through Express Scripts
- Dental Insurance provided though United Concordia or Delta Dental
- Member Assistance Program (MAP) benefits provided though Beacon Health Options

Claims (and appeals) for these benefits must be submitted to the organization (generally the HMO or the insurance company) providing the benefit and will be processed in accordance with that organization's claims and appeals procedures, which are described in separate documents issued by the organization. You may obtain the claims and appeals procedures by contacting the organization (or you may contact the Administrative Office for assistance). For example, if you are enrolled in Health Net, an appeal for medical benefits must be submitted to Health Net and will be processed in accordance with Health Net's claims and appeals procedures, which can be obtained by calling Health Net's customer service department.

10. General Rules

What is a Claim? A Claim is a request for benefits submitted by you or your Authorized Representative in accordance with these claims and appeals procedures. A Claim is not: (1) a mere request for information about plan benefits; or (2) a dispute concerning eligibility for plan benefits, including COBRA coverage, that is unrelated to any specific Claim.

Authorized Representative. You may designate an "Authorized Representative" to act on your behalf in filing a Claim or appeal or requesting an external review. Your designation must be in writing on a form acceptable to the Board of Trustees and submitted to the Administrative Office. An Authorized Representative designation will be valid until it is revoked or otherwise expires. You may revoke a designation at any time by submitting a written request to revoke the designation to the Administrative Office. *Any reference to "you" in these claims and appeals procedures also includes your designated Authorized Representative*.

Requirement to Exhaust the Plan's Internal Claims and Appeals Procedures. You must first exhaust the Plan's internal claims and appeals process before filing a civil action under ERISA Section 502(a) against the Plan or the Board of Trustees. This means that before you may take legal action, you must follow all of the applicable procedures for filing an internal claim and an appeal as described in this document.

Failure to Follow Procedures. If the Plan fails to substantially follow these claims and appeals procedures, and it does not correct the error without prejudice to you, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedies under ERISA Section 502(a).

Limitation on When a Lawsuit May Be Filed. You may not commence a lawsuit or other legal action to obtain Plan benefits until after all administrative procedures have been exhausted (including the exhaustion or deemed exhaustion of this Plan's claims and appeals procedures), for every issue relevant to a Claim for benefits under the Plan. However, you are not required to exhaust the Plan's external review process before seeking a judicial remedy for claims involving a rescission.

No lawsuit may be filed (started) more than three (3) years after the end of the year in which services were provided.

Authority of the Board. The Board of Trustees has the absolute right, in its sole discretion, to make factual determinations relating to benefit Claims, and to interpret the terms of this Plan.

11. Life Insurance and Accidental Death & Dismemberment Benefits

The following claims and appeals procedures apply to Claims for Life Insurance and Accidental Death & Dismemberment benefits provided directly by the Fund, which are described in Articles XII and XIII of this SPD.

A. Filing a Claim

To file a Claim, you or your beneficiary must submit a written request for a benefit to the Administrative Office, along with any required supporting documentation (such as a death certificate). Claims for Life Insurance benefits must be filed within one year after the date of death. Claims for Accidental Death & Dismemberment benefits must be filed within one year from the date of loss resulting from the accident. Claims filed after these deadlines will be denied. A Claim is considered filed on the date it is received by the Administrative Office (or on the date postmarked, if mailed to the Administrative Office through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

B. Processing a Claim

You will be notified, in writing, of the Plan's decision within 90 days after your Claim is filed. This 90-day period may be extended by up to an additional 90 days if special circumstances require an extension of time for processing. You will be notified of an extension before it is taken, the reason for the extension, and the date a decision is expected. You can always allow the Plan to take more time to process your Claim.

If your Claim is denied, in whole or in part, you will receive a denial notice that: (a) states the specific reason(s) for the denial; (b) refers to the specific Plan provision(s) on which the denial is based; (c) describes any additional material or information necessary for you to perfect your Claim and explains why such material or information is necessary; (d) describes the Plan's internal appeal procedures, including the time limits applicable to such procedures and information on how to file an appeal; (e) states that you are entitled to receive, upon request, free access to and copies of documents relevant to your Claim; and (f) states your right to bring a civil action under ERISA Section 502(a) following the denial of your Claim on appeal.

C. Filing an Appeal

If you believe you have been denied a benefit improperly, or received a benefit less than the benefit to which you are entitled, you may submit a written request to the Board of Trustees asking for a review of the denial (this is called an "appeal").

Your appeal must be filed with the Administrative Office within 180 days after you receive the written denial notice. An appeal is considered filed on the date it is received by the Administrative Office (or on the date postmarked, if mailed to the Administrative Office through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

Your appeal must be in writing and include your name, mailing address, telephone number, and the basis for your appeal. You may submit any written comments, documents, records, evidence, testimony, and other information relating to your Claim to support your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim.

D. Processing an Appeal

Your appeal will receive a full and fair review by the Board of Trustees. The Board will consider all of the written comments, documents, records, evidence, testimony, and other information submitted by you that relates to your Claim, regardless of whether such information was submitted or considered in the initial review. You have no right to appear personally before the Board. The Board will exercise its reasoned discretion and authority in making, interpreting, and applying Plan rules, and in resolving any appeals. The Board's decision will be conclusive and binding upon all persons and for all purposes.

Your appeal will be decided at the Board meeting that occurs at least 30 days after the date the appeal is filed. The time for deciding your appeal may be extended to the third meeting after the appeal is filed if special circumstances require an extension of time for processing, or longer if you are asked to submit information necessary to make a determination on the appeal. You will be notified of an extension before it is taken, the reason for the extension, and the date a decision is expected. If asked to submit information necessary to decide the appeal, you will be given at least 45 days to respond, and the time for the Board's decision will be suspended from the date of the extension notice until the earlier of the date you respond or the due date set by the Board. You may voluntarily agree to extend the time for the Board to process your Claim. You will be provided with a written notice of the decision within 5 days after the Board makes its decision.

If your Claim is denied on appeal, you will receive a denial notice that: (a) states the specific reason(s) for the denial; (b) refers to the specific Plan provision(s) on which the denial is based; (c) states 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; and (d) states your right to bring an action under ERISA Section 502(a).

12. Disputes Concerning Eligibility Determinations

If you believe that you or your Dependents have improperly been denied enrollment or eligibility for any benefit under the Plan, but you don't have a Claim for a specific benefit and there has not been a rescission of coverage (as defined in Article II, Section 12), you may submit a written request to the Board of Trustees asking for a review of the denial (this is called an "appeal").

The appeals procedures applicable to Life Insurance and Accidental Death & Dismemberment benefits, which are set forth above in Section 3.A. ("Filing an Appeal") and Section 3.B. ("Processing an Appeal") of this Article XVI, will apply, except that you have 60 days after you receive a written denial notice to file your appeal with the Administrative Office, and you will be provided with a written notice of the decision within 20 days after the Board makes its decision.

13. Disputes Concerning Rescissions of Coverage

If you believe that Plan coverage for you or your Dependent has been improperly rescinded (i.e., terminated retroactively) under Section 12 of Article II of this SPD, you may submit a written request to the Board of Trustees asking for a review of the rescission.

A. Additional Procedures for Rescissions

The appeals procedures applicable to Life Insurance and Accidental Death & Dismemberment benefits, which are set forth above in Section 3.C. ("Filing an Appeal") and Section 3.D. ("Processing an Appeal") of this Article XVI, will apply, subject to the following exceptions:

i. Your appeal must be filed within 180 days after you receive the written rescission notice.

ii. You will be automatically provided, free of charge, the following: (a) any new or additional evidence considered, relied upon, or generated in connection with the decision to rescind your coverage; and (b) any new or additional rationale for a denial upon appeal. This information will be provided as soon as possible, sufficiently before the decision on appeal is made, so that you will have a reasonable opportunity to respond before a final decision on appeal is rendered. If applicable, you will be provided, upon request and free of charge, the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the decision to rescind your coverage, regardless of whether the advice was relied upon in making the determination.

iii. The Board of Trustees, which is neither the entity that made the initial decision to rescind your coverage nor the subordinate of such entity, will make an independent determination and will not afford deference to the initial review.

iv. The Board's decision will be conclusive and binding upon all persons and for all purposes, except in the limited circumstance that your dispute is submitted to the external review process, in which case the decision of the IRO will be final.

v. The appeal denial notice will also include the following: (a) a statement of your right to request an external review by an independent review organization, including a description of the external review process; (b) a statement of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the external review process; and (c) a statement of your right to bring a civil action under ERISA Section 502(a) following the denial of your request on appeal or under the Plan's external review process.

B. Recourse after Denial on Appeal

If your appeal is denied, in whole or in part, you have the following options: (i) you may submit your dispute to the external review process; (ii) you may bring an action under ERISA Section 502(a); or (iii) you may bring an action under ERISA Section 502(a) after exhausting the external review process.

C. External Review

External review is conducted by an accredited independent review organization ("IRO") that is independent of the Plan and the Board of Trustees. When you request an external review of a rescission, the Plan will turn over all related information to the IRO conducting the external review. There is no cost to you for requesting external review.

To request an external review of the Plan's decision to rescind your coverage, you must submit a written request to the Administrative Office within 4 months of receiving the appeal denial notice (or, if a decision on appeal has not yet been reached because you are deemed to have exhausted the administrative remedies available under the Plan, within 4 months of receiving the notice of rescission).

When it receives your request, the Administrative Office will conduct a preliminary review to determine whether your request is eligible for external review, and will notify you in writing of its determination within 6 business days.

If your request is eligible for external review, the Administrative Office will assign your request to an IRO. The IRO will notify you in writing of the request's eligibility and acceptance for external review.

The Administrative Office will provide the IRO with any documents and information that was considered in connection with the rescission within 5 business days after your external review request has been assigned to the IRO. If the Administrative Office fails to comply with this requirement, the IRO may terminate the external review and reverse the Plan's decision, in which case the IRO will notify you and the Administrative Office within one business day of making its decision.

Within 10 business days after receiving the IRO's notice, you may submit additional written information regarding the dispute to the IRO, which the IRO will consider when conducting its review and will forward to the Administrative Office within one business day of receipt. Upon receipt of the additional information, the Board of Trustees (or the Appeals Committee) may reconsider its decision to rescind your coverage. Such reconsideration, however, will not delay the external review. If, upon reconsideration, the Board of Trustees (or Appeals Committee) reverses its decision, it will provide written notice of its decision to you and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

The IRO will review all of the information and documents timely received. In addition, the IRO may consider additional, appropriate information. In reaching a decision, the IRO will review the Trustees' determination as if it is new and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals procedures. However, the IRO will be bound to observe the terms of the Plan, unless the terms of the Plan are inconsistent with applicable law.

The IRO will notify you and the Administrative Office in writing of its decision within 45 days after receiving your external review request. The IRO's notice will contain the following: (a) a general description of the reason for the external review request; (b) the reason for the previous denial; (c) the date the IRO received the request and the date of its decision; (d) references to the evidence or documentation considered by the IRO in reaching its decision, including the specific coverage provisions and evidence-based standards; (e) a discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision; (f) a statement that the IRO's determination is binding, except to the extent that the dispute is submitted to binding arbitration pursuant to applicable State law; and (g) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

If the IRO reverses the Plan's decision to rescind your coverage, the Plan will provide coverage upon receipt of the IRO's notice. If the IRO upholds the Plan's rescission, you may bring an action under ERISA Section 502(a).

14. Claim Denials Involving a Determination of Disability

If you believe that your Claim was denied because you were improperly denied disability credits under Article II, Section 8 of this SPD ("Extended Eligibility for Disability Credit"), the claims and appeals procedures applicable to Life Insurance and Accidental Death & Dismemberment benefits, which are set forth above in Section 3 of this Article XVI, will apply, subject to the following exceptions:

A. The appeal described in Section 3.C. of this Article XVI ("Filing an Appeal") must be filed within 180 days after you receive the denial notice.

B. The appeal review procedure described in Section 3.D. of this Article XVI ("Processing an Appeal") will also: (a) afford no deference to the initial adverse determination and provide for a review that is conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the initial adverse benefit determination or that person's subordinate, (b) for denials based on medical judgment, include consultation with a health care professional who has appropriate training and experience in the field of medicine involved, was not consulted in connection with the initial denial, and is not that person's subordinate, (c) provide, upon request, the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan, and (d) provide, free of charge and sufficiently in advance of the denial date, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim and/or any new or additional rationale for the denial.

C. The appeal denial notice described in Section 3.D. of this Article XVI ("Processing an Appeal") will include the following additional information: (a) a discussion of the decision, including an explanation of the basis for disagreeing with or not following any Social Security Administration disability determination, or the views of the health care or vocational professionals presented by you or obtained by the Plan; (b) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided to you, upon request and free of charge; and (c) the specific internal rules, guidelines, protocols, standards, or similar criteria of the Plan relied upon in making the adverse determination, or, alternatively, a statement that such information does not exist.

XVII. GENERAL PROVISIONS AND INFORMATION ABOUT THE PLAN

P. Name of the Plan

The name of the Plan is the Santa Monica UNITE HERE Health Benefit Plan.

15. Name and Address of the Board of Trustees

Board of Trustees of the Santa Monica UNITE HERE Health Benefit Plan
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017
(866) 345-5189 or (562) 463-5075
www.santamonicauniteherefunds.org

A complete list of the Employers and employee organizations sponsoring the Plan, or information as to whether a particular employer or employee organization is a sponsor of the Plan (and, if so, the sponsor's address), may be obtained upon written request to the Administrative Office.

16. Employer Identification Number

The taxpayer identification number assigned to the Plan by the Internal Revenue Service is EIN 95-6035138. The plan number is 501.

17. Type of Plan

The Plan is a welfare benefit plan that provides medical, prescription drug, dental, vision, member assistance program, life insurance, and accidental death and dismemberment benefits.

18. Type of Administration

The Board of Trustees has contracted with insurers and a third party administrator to conduct the daily operations of the Plan.

Certain Plan benefits are provided through contract or insurance with the following service providers:

For Medical Benefits

Health Net of California, Inc.
PO Box 9103
Van Nuys, CA 91410
(800) 522-0088

Kaiser Foundation Health Plan, Inc.
3100 Thorton Ave.
Burbank, CA 91504
(818) 557-3968

For Retail Prescription Drug Benefits

Express Scripts Claims Dept.
STL – 1409
P.O. Box 63166
St. Louis, MO 63166

For Mail Order Prescription Drug Benefits

Express Scripts, Inc.
P.O. Box 66568
St. Louis, MO 63166
(800) 606-5667

For Dental Insurance

United Concordia Companies
21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367
(818) 710-9400

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
(800) 765-6003

For Member Assistance Program ("MAP") Benefits

Beacon Health Options, Inc.
P.O. Box 6065
Cypress, CA 90630-0065
(888) 479-6606

19. Name, Address, and Telephone Number of the Plan Administrator

Board of Trustees of the Santa Monica UNITE HERE Health Benefit Trust Fund
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 900171906
(866) 345-5189 or (562) 463-5075

20. Name and Address of Agent for Service of Process

The Board of Trustees has appointed the following as its agent for service of legal process:

Mr. Lance Phillips
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906

Service of legal process may also be made on a Plan Trustee or the Plan Administrator.

21. Names and Addresses of Trustees

Employer Trustees

Teri Serrano
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017

Yohanys Lamas Castro
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, California 90017

Union Trustees

Kurt Petersen
UNITE-HERE Local 11
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

Tom Walsh
UNITE-HERE Local 11
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

Austin Lynch
UNITE-HERE Local 11
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

Karine Mansoorian
(Alternate Trustee)
UNITE-HERE Local 11
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

22. Collective Bargaining Agreements

The Plan is maintained pursuant to one or more Collective Bargaining Agreements. Upon written request, the Administrative Office will advise an Employee or Dependent if a particular employer has entered into a Collective Bargaining Agreement requiring contributions to the Fund. Copies of any Collective Bargaining Agreement may be obtained by Employees and their Dependents upon written request to the Administrative Office and is available for examination by Employees and their Dependent's at the Administrative Office.

23. Source of Contributions

The Plan is funded by Employer contributions, as specified in Collective Bargaining Agreements. Employees and Dependents may pay premiums as required for COBRA coverage.

24. Right to Recover Overpayments

Whenever a benefit payment (including premiums for HMO coverage) exceeds the amount that should have been paid (an "overpayment"), the Fund shall have the right to recover the overpayment (plus interest at the same annual rate imposed for delinquent Employer contributions) from any person or organization to, or for, whom said payments were made or from any person whose acts, omissions, or representations caused overpayments. In the event that the Fund brings legal action to recover any such overpayment, the Fund shall be entitled to recover its costs and attorney's fees incurred in such action.

25. Funding Medium

All Plan assets are held in the Santa Monica UNITE HERE Health Benefit Trust Fund ("Fund"). The MLK Program is funded directly by the Fund. Other Medical, dental, vision, and member assistance program benefits are provided through insurance contracts between the Santa Monica UNITE HERE Health Benefit Trust Fund and various HMOs and insurance companies. For insured benefits, the insurer is responsible for paying claims and providing benefits, not the Fund.

26. Plan Year

The records of the Plan are maintained on a calendar year basis. The end of the Plan Year is December 31.

27. Statement of Participants' and Beneficiaries' ERISA Rights

Participants in the Plan (Employees and Dependents enrolled for coverage) 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

a. Examine, without charge, at the Administrative Office during usual business hours, all documents governing the Plan, including insurance contracts, provider service agreements, the Collective Bargaining Agreement under which a participant is covered and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor, and are available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain 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, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for the plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person may fire you or discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them in 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, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about your plan, you should contact the 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.