Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund

SUMMARY PLAN DESCRIPTION

AND PLAN DOCUMENT

January 1, 2022

A MESSAGE TO ALL EMPLOYEES AND BENEFICIARIES

The Board of Trustees of the Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund is pleased to present the health and welfare benefits of the Plan outlined in this booklet. This booklet is intended to serve as your Summary Plan Description/Plan Document.

This Plan was established as a result of collective bargaining between the Union and the Employers. The Plan is funded under the terms provided for in the applicable Collective Bargaining Agreements between the bargaining parties.

Please read the booklet carefully so that you will understand the benefits available to you and your family, and special steps you need to take to receive the highest level of coverage.

The benefits available under the Plan are of tremendous value to you and your family. While you will be responsible for certain expenses that occur with illness or injury, this Program will greatly lessen the financial burden caused by them.

Don't forget to notify the Fund Office whenever any of the following happen:

- Your address, or the address of your dependents change,
- Marriage, divorce, change in Domestic Partnership or change in the status of a dependent child,
- Medicare enrollment or disenrollment,
- Existence/change in other employer-sponsored coverage.

If you have any questions about your eligibility or benefits, please call the Fund Office at (855) 690-7250.

Sincerely,

Board of Trustees

Union Trustees	**Employer Trustees**
Dennis Hart	Jeff Carlsen
Jesse Casqueiro	Keely Khan
Mark Hawkins	Chris Lopez
Brian Indelicato	Penny Schumacher
	Robert Graham (Alternate)

ONLY THE FULL BOARD OF TRUSTEES IS AUTHORIZED TO INTERPRET THE PLAN OF BENEFITS DESCRIBED IN THIS BOOKLET, AND NO INDIVIDUAL TRUSTEE, UNION REPRESENTATIVE OR EMPLOYER REPRESENTATIVE IS AUTHORIZED TO INTERPRET THIS PLAN ON BEHALF OF THE BOARD OR TO ACT AS AN AGENT OF THE BOARD. THE TRUSTEES HAVE AUTHORIZED THE FUND OFFICE TO RESPOND IN WRITING TO WRITTEN INQUIRIES FROM PLAN PARTICIPANTS. AS A CONVENIENCE TO PARTICIPANTS, THE FUND OFFICE WILL PROVIDE ORAL ANSWERS REGARDING COVERAGE ON AN INFORMAL BASIS. HOWEVER, NO SUCH ORAL COMMUNICATION IS BINDING UPON THE BOARD OF TRUSTEES.

Benefits are NOT Vested

Participants should understand that health care benefits are not vested rights and that the Trustees have full authority to modify, limit or terminate health care benefits at any time as they deem appropriate. Benefits shall be provided only so long as there are allocated funds available to pay for such benefits.

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SUMMARY OF IMPORTANT TELEPHONE NUMBERS

Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund Office
c/o Health Services & Benefit Administrators
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Telephone: (855) 690-7250
Facsimile: (925) 833-7301

Anthem Blue Cross
Medical Review Organization
(800) 274-7767

Anthem Blue Cross
PPO Dental Plan
(844) 729-1565

Kaiser Permanente
(800) 464-4000

UnitedHealthcare Dental Direct Compensation
(800) 999-3367

OptumRx
(800) 797-9791

Teamsters Assistance Program (TAP)
San Francisco Bay Area: (510) 562-3600

Outside San Francisco Bay Area: (800) 253-8326

VSP Vision Care
(800) 877-7195

Si usted gustaría una copia en español, por favor de contactar la oficina de administración de Northern California Soft Drink Industry and Teamsters Health & Welfare Trust Fund Office.

ABOUT YOUR MEDICAL PLAN OPTIONS

NEW HIRES are limited to enrollment in the Anthem PPO Medical Plans during your first 18 months of Coverage. There are two options to choose from: The Basic Plan and the Enhanced Plan. New Hires are also limited to enrollment in the United Healthcare DHMO Dental Plan during your first 36 months of Coverage under the Plan. After 18 months of coverage under the Plan, you may enroll in the Kaiser HMO Medical Plan option, and after 36 months of coverage under the Plan, you may enroll in the Anthem PPO Dental Plan option.

HOW THE ANTHEM PPO MEDICAL PLANS AND KAISER HMO MEDICAL PLAN WORK

While only the Anthem PPO Medical Plan options are described in this book, the following chart illustrates how Medical Benefits are provided through the Anthem PPO Medical Plans and the Kaiser HMO Medical Plan.

Plan Feature	Anthem PPO Medical Plan	Kaiser HMO Plan
Providers	You may go to any healthcare provider. However, when you use Non-PPO providers, your share of Covered Expenses will be larger with higher Coinsurance Levels and a higher Out-Of-Pocket Limit. In some cases, there is no limit to your Out-Of-Pocket expenses.	You must use Kaiser Providers in most cases, or your care may not be covered by Kaiser. This Summary is only intended for comparison purposes to the Anthem PPO Medical Plan and is not intended as your Plan booklet. For complete plan details, please contact Kaiser at (800) 278-3296 or www.kp.org.
Network	The Anthem PPO Medical Plan is a preferred provider network. You can locate a list of network providers by calling Anthem at (800) 331-1476 or visiting their website at www.anthem.com/find-care/.	Kaiser Permanente is an HMO Medical Plan with a closed panel of providers. You can locate Kaiser providers by calling (800) 278-3296 or visiting their website at www.kp.org.
Deductible	You must meet your Annual Deductible before the PPO Medical Plan pays for most services. The Annual Deductible applies to all Covered Expenses under the Medical Plan, except as noted in this Booklet. For example, the Annual Deductible does not apply to certain Preventive Care benefits or Prescription Drug Benefits.	You must meet your Annual Deductible before Kaiser pays for most covered services, including inpatient hospital care, outpatient surgery, diagnostic x-rays, MRIs, CT Scans, Hospice Care and Skilled Nursing Care. Certain Preventive Care and Prescription Drugs are not subject the Annual Deductible.
Coinsurance	Once you, or your family, meet your Annual Deductible, most services are subject to Coinsurance. Your Coinsurance requirement is lowest when you use PPO network providers. You must pay Coinsurance for services until you, or your family, reach the Out-Of-Pocket Limits.	Once you, or your family, meet your Annual Deductible, most services are subject to Coinsurance. Your Coinsurance requirement is lowest when you use PPO network providers. You must pay Coinsurance for services until you, or your family, reach the Out-Of-Pocket Limits.

Copayments	Most Medical services do not have Copayments. Copayments are mostly applicable to Prescription Drug and Vision Care benefits. The Annual Deductible does not apply to services or supplies with Copayments.	Some Medical services, Prescription Drug benefits and Vision Care benefits are subject to Copayments. Services with Copayments are generally not subject to the Annual Deductible.
Annual Out-Of-Pocket Limits	Once you, or your family, reach their Annual Out-Of-Pocket Limit, the PPO Medical Plan pays 100% of Covered Expenses. Your Annual Deductible, Coinsurance and Copayments under the Medical, TAP and Prescription Drug benefits all apply to the Annual Out-Of-Pocket Limits.	Once you, or your family, reach their Annual Out-Of-Pocket Limit, Kaiser pays 100% of Covered Expenses. Your Annual Deductible, Coinsurance and Copayments under the Medical, TAP and Prescription Drug benefits all apply to the Annual Out-Of-Pocket Limits.
Network	The Anthem PPO Medical Plan is a preferred provider network. You can locate a list of network providers by calling Anthem at (800) 331-1476 or visiting their website at www.anthem.com/find-care/.	Kaiser Permanente is an HMO Medical Plan with a closed panel of providers. You can locate Kaiser providers by calling (800) 464-4000 or visiting their website at www.healthy.kaiserpermanente.org/northern-california/front-door.

SUMMARY OF MEDICAL BENEFITS

Below is a brief summary of the Medical Plans. For a complete description of the benefits listed below, including any exclusions or limitations, refer to the appropriate section of this booklet.

MEDICAL PLAN OPTIONS AND BENEFITS SUMMARY					
Plan Features	**Anthem PPO Medical Plan**				**Kaiser HMO Plan**
	Enhanced Plan		**Basic Plan**		
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
	Deductibles, Coinsurance and Copayments That You Pay				
Annual Deductible	**Calendar Year**				
Per Individual	$200		$3,000	$9,000	$200
Per Family	$400		$6,000	$18,000	$400
Annual Out of Pocket Maximum	**Calendar Year**				
Per Individual	$1,500	$5,000	$4,000	No Limit	$1,500
Per Family	$4,500	$15,000	$8,000	No Limit	$3,000
Calendar Year/ Lifetime Limit	None	None	None	None	None

MEDICAL PLAN OPTIONS AND BENEFITS SUMMARY

Plan Features	Anthem PPO Medical Plan				Kaiser HMO Plan
	Enhanced Plan		Basic Plan		
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
	Deductibles, Coinsurance and Copayments That You Pay				
Inpatient Hospital		Allowable Charges Semi-Private Room*		Allowable Charges Semi-Private Room*	
Room and Board*	10%	30%	40%	60%	10%
Intensive Care	10%	30%	40%	60%	10%
Ancillary Charges	10%	30%	40%	60%	10%
Prior Authorization	Automatic	**Required. Call Anthem at (800) 274-7767**	Automatic	**Required. Call Anthem at (800) 274-7767**	Automatic
Ambulance Services	10%		40%		$150 per Trip
Diagnostic -Imaging and Lab	10%	30% of Allowable Charges	40%	60% of Allowable Charges	Diagnostic tests $10/encounter. Imaging (CT/PET/MRI) 10% up to $50 per procedure.
Physician Visits -Office, Telehealth, Hospital, Home Health (including podiatry and chiropractic care)	10%	30% of Allowable Charges	40%	60% of Allowable Charges	$25 per Visit. *Chiropractic Care is not covered.*
Routine Physical Exams and Preventive Care	Most services are covered at 100%	30% of Allowable Charges	Most services are covered at 100%	60% of Allowable Charges	Most services are covered at 100%
Well Child Care and Immunizations	Most services are covered at 100%	30% of Allowable Charges	Most services are covered at 100%	60% of Allowable Charges	Most services are covered at 100%
	A complete list of Preventive Care Services (Adult, Women and Children) which are covered at 100% at Network Providers is available at www.healthcare.gov/coverage/preventive-care-benefits/				
Maternity Care for Employee & Spouse Only	10%	30% of Allowable Charges. Midwife Limited to $750.	40%	60% of Allowable Charges. Midwife Limited to $750.	Most services are covered at 100%

MEDICAL PLAN OPTIONS AND BENEFITS SUMMARY

Plan Features	Anthem PPO Medical Plan				Kaiser HMO Plan
	Enhanced Plan		Basic Plan		
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
	Deductibles and Coinsurance That You Pay				
Physical, Occupational and Speech Therapy	10%	30% of Allowable Charges	40%	60% of Allowable Charges	$25 Outpatient 10% Inpatient
Skilled Nursing Facility	10%	30% of Allowable Charges	40%	60% of Allowable Charges	10%
Home Health Care	10%	30% of Allowable Charges	40%	60% of Allowable Charges	Most services are covered at 100%
	Must be pre-authorized by Anthem and certified as Medically Necessary. Call Anthem at (800) 274-7767				
Hospice Care	10%	30% of Allowable Charges	40%	60% of Allowable Charges	Most services are covered at 100%
	Must be pre-authorized by Anthem and certified as Medically Necessary. Call Anthem at (800) 274-7767				
Durable Medical Equipment	10%	30% of Allowable Charges	40%	60% of Allowable Charges	10% No Deductible
Alcohol/Drug Rehabilitation Services (TAP)	**Call Teamsters Assistance Program at (510) 562-3600**				
-Inpatient	10%	30%	40%	60%	10%*
-Outpatient	10%	30%	40%	60%	10%*
-Prior Authorization	*Must be pre-authorized by TAP or Benefits are Reduced by 10%*				
	*Kaiser Members are also eligible for alcohol and drug rehabilitation services through Kaiser. Detoxification must be at performed by Kaiser.				

See the PPO Medical Plan section of this booklet for complete details about medical benefits

See the Substance Abuse Benefits through Teamsters Assistance Program (TAP) for complete details

For more information about Kaiser benefits, call (800) 278-3296 or visit www.kp.org

SUMMARY OF DENTAL BENEFITS

Below is a brief summary of the Dental Plans. For a complete description of the benefits listed below, including any exclusions or limitations, refer to the appropriate section of this booklet.

DENTAL PLAN OPTIONS AND BENEFITS SUMMARY			
Benefit Features	**Anthem Dental PPO Network**		**United Healthcare DHMO**
	Coinsurance That You Pay		
	PPO Dentists	Out-Of-Network	In-Network Only
Covered Charges	Based on Network Discounts with PPO Providers	Based on Allowable Charges *Providers can balance bill you for charges exceeding Plan benefits.*	Most Services are Covered at 100% **Must use Network Providers**
GENERAL DENTISTRY			
Calendar Year Deductible	None	None	None
Calendar Year Limit*	$2,000 / Person		None
Diagnostic & Preventive	Covered at 100%	15%	No Charge for Most Procedures
Basic Restorative	15%	30%	No Charge for Most Procedures
Endodontic Services	15%	30%	No Charge for Most Procedures
Periodontal Services	15%	30%	No Charge for Most Procedures
Oral Surgery Services	15%	30%	No Charge for Most Procedures
Major Restorative	30%	30%	No Charge for Most Procedures
Prosthodontic Services	30%	30%	No Charge for Most Procedures
ORTHODONTICS	**For a Pre-Treatment Estimate call Anthem at (844) 729-1565**		
Who is Covered	Dependent Children Under Age 19 Only **Banding must occur prior to age 19**		Dependent Children Ages 10 - 19 Only
Deductible	None	None	None
Coinsurance	30%	30%	None
Lifetime Benefit	$1,500 / Person	$1,500 / Person	$1,250/Person (24 months of treatment)

*The Anthem Dental PPO Calendar Year Benefit Limit is a combined amount for PPO and Out-Of-Network

Anthem assures Emergency Care within 72 hours. You can contact their customer service at (844) 729-1565, or visit them at www.Anthem.com

To choose an Anthem network provider, call (800) 627-0004 or visit www.Anthem.com

See the Dental Benefits section of this booklet for complete details

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Below is a brief summary of the Prescription Drug benefits. For a complete description of the benefits listed below, including any exclusions or limitations, refer to the appropriate section of this booklet.

PRESCRIPTION DRUG PROGRAM SUMMARY			
Plan Features	**OptumRx Prescription Drug Plan**		
	Enhanced PPO Plan	**Basic PPO Plan**	**Kaiser HMO Plan**
Calendar Year Deductible			
- Per Individual	None	$1,500	None
- Per Family	None	$3,000	None
Calendar Year Out-Of-Pocket Limit	Medical and Prescription Drug Calendar Year Out-Of-Pocket Limits Apply Separately		
- Per Individual	$6,400	$3,900	$6,400
- Per Family	$11,300	$7,800	$12,800
	Copayments/Coinsurance That You Pay		
Retail Pharmacy	Limited to a 34-Day Supply		
- Generic Drugs	$5	30%	$5
- Formulary Brand	$20	40%	$20
- Non-Formulary Brand	$45	40%	$45
-Specialty Injectables	10%, not to exceed $100		
Mail Order Pharmacy	Limited to a 90-Day Supply		
- Generic Drugs	$10	30%	$10
- Formulary Brand	$40	40%	$40
- Non-Formulary Brand	$90	40%	$90

The OptumRx prescription drug network is a broad network of retail pharmacies. If you use a non-network pharmacy, you must pay the full cost of the prescription and file a claim with OptumRx for reimbursement.

SUMMARY OF VISION CARE BENEFITS

Below is a brief summary of the Vision Care benefits. For a complete description of the benefits listed below, including any exclusions or limitations, refer to the appropriate section of this booklet.

VSP VISION CARE PLAN		
Plan Features	**VSP Network Provider**	**Non-VSP Provider**
	What You Pay	
Examination (Once every 12 months)	No Charge	Charges over $50
Lenses (One Pair Every 12 Months)		
-Single	No Charge	Charges over $50
-Bifocals (lined)	No Charge	Charges over $75
-Trifocals (lined)	No Charge	Charges over $100
-Lenticular	No Charge	Charges over $125
Frames (Once Every 24 Months)	Charges over $120	Charges over $70
Contact Lenses		
-Necessary	Covered, when approved	Charges over $210
-Cosmetic	Charges over $130	Charges over $105

SUMMARY OF DEATH AND AD&D BENEFITS

Below is a brief summary of the Death and AD&D benefits. For a complete description of the benefits listed below, including any exclusions or limitations, refer to the appropriate section of this booklet.

DEATH AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS	
Plan Features	**Plan Pays**
Death Benefits	
-Employee	$5,000
-Dependent	
Spouse	$1,500
Children (up to age 6 months)	$100
Children (Over 6 months)	$500
Accidental Death & Dismemberment	
-Employee Only	
Accidental Death	$3,000
Loss of any two: hands, feet or eyes	$3,000
Loss of any one: hand, foot or eye	$1,500

ELIGIBILITY

EMPLOYEES

Initial Eligibility

When your Employer is obligated to begin contributing to the Fund on your behalf is based on the terms of your Collective Bargaining Agreement.

You first become eligible after completing the Fund's service requirement of working (and your employer contributes for) at least eighty (80) covered hours per month, for at least three (3) months in any five (5) consecutive months.

You are eligible on the first day of the month following completion of the above service requirement.

If you take a leave-of-absence before completing the service requirement, your months of leave will *not* be credited toward initial eligibility; and the time away from work on a leave of absence will not be counted toward the five (5) consecutive months for completing the service requirement.

Example #1: You are hired in April and your employer is obligated to start contributing in April. You work at least 80 hours in April, May and July, so you will first be eligible for coverage on August 1.

Example #2: You are hired in April and your employer is obligated to start contributing in April. You work at least 80 hours in April and May but in June you are required to take a leave of absence, and do not return to work until October. You work 80 hours in October, so you will first be eligible for coverage on November 1.

New Employees must wait eighteen (18) months following initial eligibility to be eligible to enroll in the Kaiser HMO Plan. For the first eighteen (18) months, new Employees are limited to the two PPO Medical Plan options. After completion of 18 months of enrollment, participants may enroll in the Kaiser HMO Plan, in accordance with the rolling enrollment provisions of the Plan (see page 13).

New Employees must wait thirty-six (36) months following initial eligibility to be eligible to enroll in the Anthem PPO Dental Plan. For the first thirty-six (36) months new Employees are limited to the United Healthcare Dental Plan. After completing this period, participants may enroll in the Anthem Dental PPO plan in accordance with the rolling enrollment provisions of the Plan (see page 13)

To receive benefits, you must complete an enrollment form for yourself and all your eligible Dependents. You should fill out the form prior to the completion of your hours of service requirement for initial eligibility (see Enrollment).

Transfer Employees

If you change jobs but were covered under this Plan or another Teamster plan at your old job, you may be eligible to participate in this Plan after working at least eighty (80) hours in one month, notwithstanding the three-out-of-five month requirement discussed above. If you are a Transfer Employee, you become eligible under the Plan on the first day of the month following the first month in which you work a minimum of eighty (80) hours for a Contributing Employer and your Employer makes the required Contribution on your behalf and you satisfy at least one of the following conditions:

- You had one (1) month of eligibility out of the last six (6) months with the Northern California Soft Drink Industry and Teamsters Health & Welfare Trust Fund.

  OR

- You were covered for at least six (6) months under any Teamster health and welfare plan immediately prior to your transfer.

You must provide proof of such prior coverage to the Fund Office. If you were enrolled in Kaiser when you lost coverage under the circumstances described above, you can immediately re-enroll in Kaiser without waiting 18 months.

Maintaining Your Eligibility

You remain eligible under the Plan as long as you work the number of hours set forth in the Collective Bargaining Agreement and your Employer makes the required Contributions on your behalf. **The hours you work in a particular month count towards your eligibility for the next month.** In other words, if you work eighty (80) hours in May and your Employer makes a Contribution on your behalf, you will be eligible for coverage for the month of June.

If you meet the initial eligibility requirements, but then lose coverage, you will regain coverage in the month following the month you work at least eighty (80) hours.

Optional Dental and Vision Benefits

The Plan allows you to opt out of Dental and/or Vision coverage. However, the cost of coverage remains the same whether you remain in the Dental and Vision Plans or opt out of these benefits, so there is no financial advantage to you to opt out. To opt out, you need to request the form from the Fund Office. Please call the Fund Office if you have questions regarding this election.

DEPENDENTS

Your Dependents will become eligible for benefits on the same date you become eligible.

Your eligible Dependents include:

- Your lawful spouse, or Domestic Partner (as defined on page 11).
- Your natural or legally adopted children up to age 26. Legally adopted children are recognized as Dependents from the date they are placed with the Employee for adoption.
- Your stepchild up to the age of 26.
- A foster child up to the age of 26.
- Your child of any age who is incapable of supporting himself or herself because of a mental or physical handicap on the date he or she would otherwise lose coverage due to age and who remains chiefly dependent upon you for support. Written evidence of such incapacity must be furnished to the Fund Office within 31 days after your dependent attains age 26. Upon request, you must provide the Fund with evidence satisfactory to the Fund of your child's continued disability.

NOTE

If you have a spouse, Domestic Partner or covered Dependent who is working and eligible for group coverage in a separate plan through his or her employer, but decides not to enroll in the other plan, the Plan may treat the Dependent as if he or she was receiving coverage from the other plan. Specifically, if your Dependent(s) chooses not to participate, and the employee contribution required by the other plan is less than $65 per month, the Fund will pay benefits as though your spouse/Domestic Partner/Dependent had enrolled in the other group coverage with benefits identical to the Fund's PPO Plan. See "Coordination of Benefits" on page 56 for more details of this requirement.

New Dependents

If you acquire a new Dependent (*for example,* you get married, have a baby or adopt a child, or register your Domestic Partnership), you must notify the Fund Office and enroll your new Dependent within thirty (30) days. Failure to do so will delay your Dependent's coverage until your next rolling enrollment date, regardless of whether you are covered under the PPO Medical Plan or the Kaiser HMO Plan.

New Dependents enrolled within thirty (30) days are covered as of the date of marriage or birth, or in the case of adoption, the date the child is placed with the Employee for adoption.

Your Dependents must be enrolled to receive benefits.

Enrollment

To enroll yourself and your dependents, you must complete an enrollment form, which can be obtained from the Fund Office, and submit copies of the documentation listed below:

Spouse	Marriage certificate
Domestic Partner	California Domestic Partner registration form or equivalent for other jurisdictions (see below)
Dependent Children	Birth certificate, adoption papers, or Qualified Medical Child Support Order (see below)

Once enrolled coverage is retroactive to the date of eligibility. HOWEVER; Kaiser limits retroactive coverage to 60 days. The Plan will not provide coverage earlier than the carrier allows. Therefore, be sure to complete enrollment within 60 days to make sure you are covered from the date you and/or your dependent is first eligible.

Automatic Coverage Due to a Qualified Medical Child Support Order (QMCSO)

If a medical child support order is submitted to the Plan providing for the coverage of a child as a Dependent, the Fund will review the order to determine whether it satisfies the legal requirements for a QMCSO. If the Fund approves the QMCSO, the child will be enrolled as your Dependent. If the order was issued in the form of a "National Medical Support Notice" and is subsequently determined to be qualified, your child will automatically be enrolled in the Plan option in which you are enrolled, unless the Notice specifies a particular option chosen by a state child enforcement agency, in which case both you and your child will be enrolled in that option.

Domestic Partners

Domestic Partner means same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations. To establish eligibility for your domestic partner, the Plan requires proof of registration of Domestic Partnership in the form of a valid Certificate of Registration of

Domestic Partnership from a state or local government. There are no requirements for proof of relationship or waiting periods that are not also applied to married couples.

Once you establish your Domestic Partner's eligibility, he or she will be treated as a legal spouse under the Plan, to the extent permitted by law, and your Domestic Partner's children will be treated the same as stepchildren under the Plan.

After establishing a Domestic Partnership, you and your Domestic Partner must notify the Fund Office if either of you terminate the Domestic Partnership, or if either of you file a Notice of Termination of a Domestic Partnership with a state or local government.

Tax Consequences of Domestic Partner Eligibility

Federal tax laws require the Fund to determine how much of the monthly Employer Custodial Care to the Fund is attributable to the coverage of your Domestic Partner and to **report that amount as additional taxable income paid to you.** This additional taxable income applies unless you can show that for purposes of your federal income tax returns you have *primary responsibility* for your Domestic Partner's living expenses. In other words, if your Domestic Partner has a job or supports himself or herself through his or her own work, you will have to pay the employee payroll taxes each quarter on part of the monthly Employer Contribution paid on your behalf. The amount of the monthly Employer Contribution deemed "income" will be calculated by the Fund once a year and is likely to be 40% or more of the monthly Employer Contribution.

If your Domestic Partner is not your "dependent" for federal income tax purposes, the "additional income" described above is also subject to *employer* withholding. For your Domestic Partner to be covered your employer must agree to pay the employer payroll taxes on the value of your Domestic Partner coverage. If you want to enroll a Domestic Partner, call the Fund Office. If your Domestic Partner is not your dependent, ask for a notice indicating the "fair market value" of the Domestic Partner coverage as well as a form for your employer to fill out indicating either that it will pay its share of the payroll taxes for your Domestic Partner coverage or affirm that it does not consider your Domestic Partner's benefits as taxable income. If your Domestic Partner is also your dependent, you will be asked to provide supporting documentation and/or complete an attestation form certifying that you have primary responsibility for your Domestic Partner's living expenses.

TERMINATION OF COVERAGE

Your coverage under the Plan will terminate upon the earliest of:

- the date the Plan terminates;
- the last day of the month for which your Employer has made Contributions to the Plan on your behalf;
- the date your Employer withdraws from the Plan and ceases to be a Contributing Employer;
- the 32nd day after your full-time military service begins; or
- the last day of the month during which you retire or begin receiving a pension.

Your Dependents' coverage ends on the earliest of:

- the day your coverage ends;
- the last day of the month during which your Dependent ceases to qualify as a Dependent; in the case of your spouse or step children—copy of divorce decree required.
- the date of your death
- the last day of the month during which you discontinue your Dependent's coverage;
- the day your Dependent enters full-time military service; or
- the date on which the Plan terminates.

IF YOU FAIL TO NOTIFY THE FUND OFFICE OF A DEPENDENT'S LOSS OF DEPENDENT STATUS, YOU OR YOUR DEPENDENT MAY BE RESPONSIBLE FOR THE CHARGES SUBMITTED BY YOUR FORMER DEPENDENT. FOR EXAMPLE, IF YOU DIVORCE YOUR SPOUSE AND DO NOT NOTIFY THE FUND OFFICE WITHIN 60 DAYS OF THE DIVORCE, BOTH YOU AND YOUR FORMER SPOUSE MAY BE HELD RESPONSIBLE FOR ANY BENEFITS THAT WERE PAID BY THE PLAN AFTER YOUR DIVORCE.

ROLLING ENROLLMENT

You will be given the opportunity to change your benefit program selection(s) one time in any given 12-month period provided you have maintained enrollment in your current selection for at least twelve months. All of your Dependents are covered in the same option you choose for yourself, if they are properly enrolled in the Plan. Rolling enrollment does not apply to those who have not satisfied the 18 or 36-month waiting periods described on pages 24 and 45.

Changes in Family Status

If you have a change in family status during the year (such as marriage, divorce, legal separation, starting or terminating a domestic partnership, birth or adoption of a child or death of any Dependent) or you lose coverage under your spouse's or domestic partner's plan, or a Dependent or domestic partner currently not enrolled loses other insurance coverage, you will be allowed to revise your coverage option, provided you notify the Fund Office within 30 days of the change. This change will be effective the first day of the month following the status change (except newborns who are effective the date of birth).

If you are enrolled in the Kaiser medical plan or the UnitedHealthcare dental plan and you move out of the Kaiser or UnitedHealthcare service area, you can request that you and your Dependents change medical or dental plans, provided you notify the Fund Office within 30 days of the date you change your residence. Your new plan will be effective on the first day of the calendar month following the month that the Fund Office receives your new enrollment form.

To make changes to your coverage, obtain a new enrollment form and return it to the Fund Office with appropriate documents.

Special Enrollment Rights Under SCHIP and Medicaid

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

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

EXCEPTIONS TO TERMINATION OF COVERAGE

Family Medical Leave Act

The Family Medical Leave Act (FMLA) provides that employers of fifty (50) or more Employees must grant family medical leave to Employees who qualify under the Act and must continue the medical coverage of Employees who are on FMLA leave.

Neither the Trustees nor the Fund determine whether you are entitled to FMLA leave with continuing medical coverage. Any disputes regarding your entitlement to FMLA leave and / or continuing medical benefits while on such leave must be resolved by your Employer and your Union.

To the extent that you are entitled to FMLA leave with continued medical coverage, the Fund will continue your medical coverage under the Plan, provided your Employer makes the required monthly Contributions to the Fund. Your rights under the FMLA are independent of your rights to COBRA Continuation Coverage (see page 14) or the Plan's provisions for continuing medical care in the case of disability.

You may experience a COBRA Qualifying Event if you do not return to work at the end of your FMLA leave or, if during such leave, you give your Employer notice that you do not intend to return to work.

Note: If you are on an approved FMLA leave of absence, only failure to return to work at the end of the approved leave constitutes a COBRA Qualifying Event.

Your FMLA Leave ends at the end of the month in which the earliest of the following takes place.:

- you inform your Employer you are not returning to work;
- you do not return at the end of the approved leave; or
- you reach the end of the leave period granted under FMLA.

Waiver of Contribution During Total Disability

If you or your Dependent suffer a Total Disability (as defined on page 14) that prevents you from working, you will remain eligible under the Plan even if your Employer stops contributing to the Fund on your behalf until the earlier of:

- the date on which you or your Dependent is no longer Totally Disabled; or
- four (4) calendar months after the date the Total Disability commences.

If you are still Totally Disabled after the four month "Waiver of Contribution" period, you may purchase COBRA Continuation Coverage from the Plan for an additional 14 months (or up to 25 months if you qualify for a COBRA disability extension.) If you remain Totally Disabled and choose not to continue your coverage under COBRA, you may still be eligible for an Extension of Benefits (see below) but only for the treatment of the disabling condition.

If a Physician determines that you are no longer Totally Disabled during or after the four month "Waiver of Contribution" period and releases you to return to work, your new eligibility date will be the first day of the

month immediately following the first month during which you work eighty (80) hours for a participating Employer and the Employer makes the Contribution on your behalf, provided that:

- you return to work within three (3) months after the date of your Doctor's release; and
- your Employer makes the required Contribution to the Plan on your behalf.

If you do not return to work with your Employer as described above, you will be subject to the eligibility requirements for new Employees. You are entitled to only one (1) disability waiver during any twelve (12) month period.

Extension of Benefits for Disabling Condition (not applicable to Kaiser HMO Plan participants)

If you or your Dependent is Totally Disabled when your coverage under the Plan terminates, the Plan will continue to pay benefits for treatment related to the disabling condition. Benefits are payable only for expenses arising from the disability and the extension of benefits will end the earlier of:

- the date you or your disabled Dependent becomes covered under any other group medical benefit or services plan;

- twelve (12) months after the date on which your active coverage under the Plan terminated; or

- the date on which you or your Dependent recovers from the Total Disability.

Leave for Military Service

The Uniformed Services Employment and Re-Employment Rights Act (USERRA) provides that you can continue your coverage if you leave your job for active military duty or training for a period not to exceed 31 days. If your military service extends beyond 31 days, you may self-pay for your coverage for up to 24 months from the date the leave started or the date you do not return from your leave, whichever occurs first.

If your coverage terminates by reason of service in the uniformed services, an exclusion or waiting period may not be imposed in connection with the reinstatement of your coverage when you return to work. However, this requirement does not apply to the coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. Regardless of whether you elect to self-pay for extended coverage, your coverage will be reinstated immediately when you return to employment immediately following your leave and your Employer will be charged for the cost of your coverage even though you did not work the prior month.

You must elect this coverage; it is not automatic. If you do not give advance notice of your military leave, you will not be eligible to elect USERRA coverage unless your failure to provide such notice is excused under USERRA because it was impossible, unreasonable, or precluded by military necessity, in which case your coverage will be restored retroactively upon payment of all unpaid amounts due. If you give advance notice of your leave, you may elect USERRA coverage at any time within the first 60 days after your last day of employment. You may elect either "Core-Only" or "Core-Plus" coverage, as described on page 19.

Your first self-payment for USERRA coverage is due within 45 days of the date of your election and must be retroactive to the date your Employer-paid coverage ends. Subsequent payments are due on the first of the month and are delinquent if not received by the 30th day of the month. If your payment is significantly less than the actual payment due (as described under "COBRA Continuation Coverage," on page 16) your coverage will be terminated immediately.

The duration of the leave combined with all your previous periods of military leave under the same Employer must not be more than five years (unless extended by national emergency or similar circumstance). You may not "stack" USERRA Continuation coverage and COBRA – they run concurrently.

For more information about USERRA, please contact the Fund Office at (855) 690-7250.

CONTINUATION OF COVERAGE

The Plan provides several options to continue your coverage after your employer paid coverage ends. **These options require you to pay the Fund directly for your coverage and are of limited duration.**

Direct Payment Option

If you lose coverage due to temporary layoff, you may make direct payments to the Fund for a maximum of six (6) consecutive calendar months within any twelve (12) month period. The amount of payment is determined annually by the Board of Trustees. You must remain available for active work for a Contributing Employer during the period you elect to continue your coverage under this provision.

COBRA Continuation Coverage

COBRA is a federal law that permits you and your eligible Dependents to continue health coverage at your expense when you would otherwise lose your group health coverage due to a "Qualifying Event." COBRA applies to medical, prescription drug, dental and vision coverage, but not to the death benefit or accidental death and dismemberment benefits.

Specific Qualifying Events are listed below. You, your spouse and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of a Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the Fund directly for the coverage. The payment is 102% of the cost to the Plan to provide the COBRA coverage and will continue your medical, prescription drug, dental and vision coverage.

If you are an Employee, you will become a Qualified Beneficiary if you lose your Plan coverage because of either of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason.

If you are the spouse of an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan as a result of any of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason; or
- You divorce or become legally separated from your spouse.

Your Dependent children will become Qualified Beneficiaries if they lose Plan coverage as a result of any of the following Qualifying Events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason;
- The parents become divorced or legally separated; or
- The child's eligibility as a "Dependent" under the Plan ends (e.g., the child reaches the maximum age limitation).

You, your spouse and / or your Dependent children who are covered under the Plan on the day before a Qualifying Event are eligible for COBRA continuation coverage. Children born to you or placed for adoption with you during the time you are on COBRA coverage are also eligible for coverage if you add them within thirty (30) days of the birth or adoption. Family members who become eligible to enroll for COBRA coverage due to special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) while you or your Dependents are on COBRA coverage may be added to the coverage.

COBRA-like continuation coverage is available to domestic partners and their children to the same degree and in the same manner as continuation coverage is available to spouses and step-children.

Note: If you experience a Qualifying Event, begin purchasing COBRA continuation coverage and then get married, you may add your new spouse to your continuation coverage within thirty (30) days of the marriage but he or she will **not** be entitled to COBRA coverage in the event that you die or subsequently divorce.

COBRA Notification Requirement

Once the Fund Office receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. When the Qualifying Event is the end of employment, a reduction of employment hours or the death of the Employee, the responsibility for the notification of the Fund Office lies with the Employer. Notification by the Employer must take place within thirty (30) days. If the Qualifying Event is a divorce, legal separation or a child no longer meeting the Dependent eligibility rules, you must so inform the Fund Office within sixty (60) days of the date of the Qualifying Event, or the date coverage ends, whichever is later. Notice can be provided by anyone acting on your, or your Dependent's, behalf. If you fail to provide such notice within this time period, you will not be able to elect COBRA continuation coverage. The notice must contain, at a minimum, your name as well as the name of your Dependents (if any) who seek COBRA coverage, a description of the Qualifying Event and the date on which the Qualifying Event occurred. You must send this notice to:

Fund Administrator
Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund
c/o Health Services & Benefit Administrators
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Telephone: (855) 690-7250

COBRA Election

After learning of a Qualifying Event, the Fund Administrator will send a letter to you and your Dependents explaining the options to continue coverage. This letter and an election form will be sent to the address of record maintained by the Fund Office. **You and your Dependents are responsible for keeping your mailing address up to date with the Fund Office.**

It is important that you read this letter carefully. You and your Dependents have 60 days to decide if you want to take COBRA continuation coverage and return the election notice to the Fund Office. This 60-day period starts either the day group health coverage is lost or the day the COBRA election notice is received, whichever is later. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA on behalf of their spouses and parents may elect COBRA on behalf of their children.

If you do not elect COBRA continuation coverage within the 60-day election period, you and/or your Dependents will have lost the right to elect COBRA continuation coverage.

If you choose COBRA coverage at any time during the 60-day election period, coverage will be retroactive to the date of the Qualifying Event. If you or your Dependents decide to waive COBRA coverage, you may revoke the waiver at any time during the 60-day election period and elect COBRA coverage. You may not revoke your waiver and elect COBRA coverage once the 60-day election period has ended.

Finally, you should take into account that you 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 employer) within 30 days after your group health coverage ends because of the qualifying event giving rise to your right to elect COBRA coverage. You will also have the same special enrollment right at the end of the maximum duration of continuation coverage available to you.

Your first COBRA payment can be sent in with the COBRA election form or sent in separately. If not sent with the COBRA election form your first COBRA payment must be received by the Fund Office within 45 days of the date you elect COBRA continuation coverage or will not be accepted. Your first payment must cover the cost of COBRA continuation coverage retroactive to the date your employer-paid coverage ended. You are responsible for ensuring that the amount of your first payment is enough to cover this entire period.

You may contact the Fund Office to confirm the correct amount of your first payment. If the first payment is not received by the end of the 45-day period described above, you will not be eligible for COBRA continuation coverage and you must pay any health expenses incurred following the end of your employer-paid coverage.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Employee, divorce, legal separation or the loss of eligibility for a Dependent child, COBRA continuation coverage lasts for up to a total of thirty-six (36) months.

When the Qualifying Event is the termination of employment or a reduction of hours of employment, COBRA generally only lasts for up to a total of eighteen (18) months. There are two ways in which this 18-month period of COBRA can be extended:

- Disability extension of the 18-month period of continuation coverage: If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, you and your family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage for a total of twenty-nine (29) months. The disability must have started at some time before the sixtieth (60th) day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To get this extension, you must send a copy of the Social Security Award to the Fund Office within sixty (60) days from the later of the date of the Social Security disability award or the date the Qualified Beneficiary loses coverage, but in no event later than the expiration of the first eighteen (18) months of COBRA continuation coverage.

  The disability extension will end on the first day of the month that is more than thirty (30) days after the disability ends. You or any affected Dependent must notify the Fund Office within 30 days of a determination that you are no longer disabled. You must mail any Social Security Administration determinations to the Fund Office at:

  Fund Administrator
  Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund
  c/o Health Services & Benefit Administrators
  4160 Dublin Blvd., Suite 400
  Dublin, CA 94568
  Telephone: (855) 690-7250

- Second Qualifying Event extension of 18-month period of continuation coverage: If your family experiences a second Qualifying Event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage for a maximum of thirty-six (36) months from the date of the first Qualifying Event if notice of the second Qualifying Event is properly provided to the Fund Office. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits or gets divorced or legally separated, or if the Dependent child is no longer eligible under the Plan. This extension is only available if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

If you become entitled to Medicare either (1) after you have elected COBRA coverage, your Dependents may continue coverage for up to 36 months from the date of the original qualifying event; or (2) within the 18 months before your termination or reduction in hours, your covered Dependents may continue coverage for up to 36 months from the date you became entitled to Medicare.

COBRA coverage runs concurrent to any coverage your Employer purchases for you after your separation from employment. ***For example*****,** if you are terminated but your Employer pays for six (6) months of coverage as part of a severance agreement, the six (6) months runs concurrently with COBRA coverage and you are only entitled to twelve (12) months of COBRA (except in the case of a disability extension, as described on page 14).

Coverage Options

Qualified Beneficiaries must choose between:

- **COBRA Core-Only:** Includes only Medical and Prescription coverage; or
- **COBRA Core-Plus:** Includes Medical, Prescription, Dental and Vision Care coverage.

Note: If you experience a Qualifying Event and elect COBRA coverage, you remain in the same benefit option (e.g., the PPO Plan or an HMO) until your next rolling enrollment date. ***For example,*** if you were covered by the PPO Medical Plan before the Qualifying Event, you may not change to the Kaiser HMO Plan until your next rolling enrollment date.

COBRA Core-Plus will cost more than COBRA Core-Only because more benefits are provided. The benefits, deductibles and co-payments under each Plan are the same as for other eligible participants. **Once you elect either Core-Only or Core-Plus coverage you may not change your election.**

Death benefits and accidental death and dismemberment benefits are not available under COBRA.

Paying for Continuation Coverage

If you elect COBRA Continuation Coverage, you pay the full cost of coverage for you and your Dependents plus a 2% administration fee—in other words, 102% of the cost. If you are disabled and qualify for the COBRA extension because of that disability, the cost of COBRA continuation coverage for the additional eleven (11) months (from the 19th to the 29th month) will be 150% of the cost. The Board of Trustees determines the COBRA premium rate annually.

After your initial payment, subsequent payments must be received at the Fund Office by the first day of the month of coverage. If you fail to pay your premium within 30 days of the due date, your coverage will automatically terminate. You will only be provided coverage to the end of the month for which payment was received. (***For example*****,** if the Fund Office has not received your COBRA premium for August coverage by August 30th, your COBRA coverage will terminate retroactive to July 31st).

Notice of Unavailability of COBRA

If you or your Dependent provides the Fund Office with the notice of a Qualifying Event, a second Qualifying Event or a determination of disability by the Social Security Administration, and the Fund determines that you or your Dependent is not entitled to COBRA coverage or extended COBRA coverage, then the Fund Office will provide the individual with a notice explaining the reasons why COBRA coverage is not available. This notice will be provided not later than fourteen (14) days after the Fund receives the notice.

Termination of COBRA Continuation Coverage

Your COBRA continuation coverage in the Plan will end automatically when:

- the Plan terminates;
- your former Employer stops participating in the Plan and transfers its Employees covered in this Plan to another plan (your COBRA rights will then transfer to the new plan);
- your or your Dependent's COBRA payment is not received by the thirtieth (30th) day of the month in which it is due;
- you become entitled to or become covered under any other group health plan that does not contain any exclusions or limitation with respect to any pre-existing condition;
- you or your Dependent becomes entitled to Medicare;
- you have a disability extension and you or your Dependent receive a final determination from the Social Security Administration that you or your Dependent is no longer disabled, effective on the first day of the month that begins thirty (30) days after the date of the final determination (***for example*****,** if you receive a final determination on May 15, your continued coverage will end on July 1);
- you or your Dependent have received continued coverage for the maximum time permitted (i.e., 18 or 36 months), or in the case of a disability extension, 29 months; or
- you or your Dependent knowingly provide the Fund Office with false material information, including, but not limited to, information relating to an individual's eligibility for coverage, in which case the Trustees may rescind coverage retroactive to the effective date of coverage.

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

For purposes of COBRA coverage, you are considered entitled to Medicare if you are enrolled in Medicare Part A or B because you are receiving social security benefits or because you applied for Medicare benefits.

If you or your Dependent remit a timely monthly Contribution to the Fund Office that is significantly less than the actual COBRA payment due for the month, COBRA continuation coverage will be terminated immediately. If you or your Dependent remit a payment that is less but not significantly less than the actual COBRA payment due for the month, the Fund Office will notify you or your Dependent of the amount of the deficiency and permit you or your Dependent to pay the deficiency within thirty (30) days of the date of the notice. You or your Dependent are responsible for paying all deficiencies. A COBRA payment will not be considered "significantly less" than the actual COBRA payment due if the shortfall is less than or equal to the lesser of $50 or 10% of the actual COBRA payment due.

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

Health Insurance Marketplace

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums 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 eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days of your loss of coverage.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at ***www.dol/gov/ebsa*** or call their toll-free number at (866) 444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit ***www.healthcare.gov.***

Conversion Privilege – HMO Participants Only

At any time during the eighteen (18) or thirty-six (36) month COBRA continuation coverage period, you may convert your HMO coverage to individual coverage. Individual coverage may cost more and provide lesser benefits than your group health plan. Contact your HMO if you are interested in this option.

Notice of Medi-Cal Health Insurance Premium Program (HIPP)

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

- have a Medi-Cal share-of-cost of no more than that provided under HIPP; and
- have a high cost medical condition, which means that your average monthly medical costs are more than twice the amount of your monthly COBRA premium.

If you are unable to work because of a disability due to HIV/AIDS, you may qualify for HIPP if your total monthly income is less than the threshold provided for by HIPP (which threshold is computed as a percentage of the poverty level established by the federal government).

To enroll in HIPP or to find out more information and if you qualify, call (916) 445-8322.

Cal-COBRA Extension of Coverage Beyond 18 / 29 Months of Federal COBRA

California law requires that your HMO provide a minimum of thirty-six (36) months of continuation coverage. "Cal-COBRA" runs concurrently with federal COBRA and runs from the date your federal COBRA began. To take advantage of Cal-COBRA, you must have been enrolled in an HMO, such as the Kaiser HMO Plan, prior to experiencing your COBRA Qualifying Event.

When and if you experience a Qualifying Event, you will receive a COBRA notice from the Fund Office. If you are entitled to less than thirty-six (36) months of federal COBRA continuation coverage and you are enrolled in the Kaiser HMO Plan, you will be sent a "California COBRA" notice from Kaiser Permanente. If you have questions regarding Cal-COBRA or Senior-COBRA, please contact your HMO directly.

Note that your coverage under Cal-COBRA or Senior-COBRA is limited to the benefits provided by the HMO, and does not include additional benefits provided by the Plan, such as vision or other benefits.

KAISER PERMANENTE HMO MEDICAL OPTION

Employees cannot enroll in the Kaiser HMO Plan until they have been covered under the PPO Plan for eighteen (18) months upon initial enrollment in the Plan. After eighteen (18) months of coverage in the Plan, you can select the Kaiser HMO Plan in accordance with the rolling enrollment provisions of the Plan (see page 13).

If you enroll in the Kaiser HMO Plan option, you must live or work within thirty (30) miles of a Kaiser Permanente facility. Most covered services will be provided at no charge or will require a small co-payment. The services covered, and your corresponding co-payments are explained in a separate booklet printed and supplied by Kaiser Permanente, called “Evidence of Coverage”.

When you enroll in the Kaiser HMO Plan option, you must receive services at Kaiser Permanente facilities. The facilities are staffed with Physicians who will provide covered medical care. If you enroll in the Kaiser HMO Plan and receive services at a non-Kaiser facility, you will be responsible for 100% of the charges (except in the case of Emergency Care, Urgent Care or an Authorized Referral out of Plan). The benefits actually provided by the Kaiser HMO Plan option are subject to the terms and conditions of the agreement between the Fund and the Kaiser Foundation Health Plan.

PPO MEDICAL PLAN

This section applies only to Employees who are enrolled in the PPO Medical Plan. If you are enrolled in the Kaiser HMO Plan, a separate booklet is available which describes those medical benefits.

In order to ensure that you receive the maximum benefit available under the Plan, please take the time to read this section carefully. By learning a few basics, your out-of-pocket costs can be substantially reduced.

PREFERRED PROVIDER (PPO) PROGRAM

The Fund has contracted with a preferred provider organization (PPO) that has a network of Preferred (PPO) Providers (Physicians, hospitals, labs and other providers) that have agreed to provide you and your Dependents with Medically Necessary professional services at discounted Contributions. These Contract Rates reduce the cost to you and the Fund and your out-of-pocket expense is less when you use PPO Providers. Anthem Blue Cross provides the Fund's PPO network.

PPO HOSPITAL COVERAGE

How Does Use of A PPO Provider Relate to How Much I Pay Out Of Pocket For My Hospital Stay Benefits?

- If you use a PPO Provider for a hospital confinement approved by the Medical Review Organization, the Plan will pay 90% of the Contract Rate (60% of the Contract Rate if you are enrolled in the Basic Plan) for most services. In addition, if you do not obtain pre-admission certification from the Medical Review Organization, you will be responsible for an additional 10% of the PPO Contract Rate.

- If you use a non-PPO Provider for a hospital confinement, the Plan will pay 70% of Covered Expenses (40% of Covered Expenses if you are enrolled in the Basic Plan) for most services, and you will be responsible for the remaining balance. In addition, if you do not obtain pre-admission certification from the Medical Review Organization, you will be responsible for an additional 10% of the Covered Expenses.

How Do I Know If My Doctor and Hospital Are PPO Providers?
The list of PPO Providers changes from time to time as providers join or leave the network. For a current list of PPO Providers or to confirm that a certain provider or facility is on the list, please go to ***www.anthem.com***. In the "Find a Doctor" section, select the Blue Cross PPO (Prudent Buyer) – Large Group network. You can also call Anthem Blue Cross at 1-800-331-1476 to obtain provider information.

What If My Doctor Is Not On Staff At A Preferred Hospital?
If your Doctor does not have privileges at a PPO Hospital, ask him / her to obtain courtesy privileges at a PPO Hospital prior to any proposed hospitalization.

What Happens In A Hospital?
Emergencies should be treated at the most convenient facility, regardless of whether or not it is a PPO Hospital. In an Emergency, you will not be penalized for using a non-PPO Hospital. However, if continued hospitalization is necessary, the Plan may require you to move to a PPO Hospital as soon as it is medically safe to transfer you. If you decline to be transferred to a PPO Hospital, your benefits will be reduced to 70% of the Covered Expenses (40% of the Covered Expenses under the Basic Plan), beginning on the date you could have been transferred.

What If There Is No PPO Hospital In My Area?
If there are no PPO Hospitals within a thirty (30) mile radius of your home, the 20% benefit reduction will not apply. Instead, the Fund will process the claim as if you were treated at a PPO Hospital. However, your out-of-pocket expenses may be less if you nevertheless use a PPO Hospital, as Contract Rates are generally lower than Covered Expenses charged by a non-PPO Provider. In all cases, **the Medical Review Organization must be contacted for all Hospital admissions, not just those at a PPO Hospital.**

What If I Require Treatment Not Available at a PPO Hospital?
In rare cases, there may be certain surgical procedures that require special facilities not available at a PPO Hospital. In the event you should require such a procedure, you must obtain prior approval from the Fund Office. If the Fund approves the procedure, your claim will be processed as if you used a PPO Hospital even though the procedure is performed at a non-PPO Hospital. Again, you must contact Anthem Blue Cross for pre-admission certification.

(The above information is for inpatient hospitalization services only. Coverage for outpatient services depends on the type of service received as described under the Section called "Covered Expenses" starting on page 29.)

ANNUAL DEDUCTIBLE

A deductible is the amount you must pay toward most Covered Expenses each calendar year before the Plan pays benefits. The deductible amounts differ between the Enhanced Plan and the Basic Plan as shown in the following table:

Covered	Enhanced Plan	Basic Plan[1]
Per Person	$200	$3,000 – PPO Provider $9,000 – non-PPO Provider
Per Family	$400	$6,000 – PPO Provider $18,000 – non-PPO Provider

Once the family deductible is reached, no further deductible amounts will be required for any family member in the rest of the calendar year.

Non-covered charges do not apply to the annual deductible.

COINSURANCE

After you satisfy the annual deductible, you and the Plan share the remaining expenses for the rest of the calendar year.

Coinsurance amounts are based on:

- Contract Rate for services or supplies provided by PPO providers; these amounts are negotiated by the PPO.

- Usual, Customary and Reasonable (UCR) amount for services or supplies provided by non-PPO providers. The Plan determines UCR amounts, as described on page 67.

[1] If you (or your family) use a combination of PPO and non-PPO providers during the year, your annual deductible will not exceed these amounts.

- Coinsurance amounts are shown in the following table:

Provider	Enhanced Plan	Basic Plan
PPO Provider	90%	60%
Non-PPO Provider	70%*	40%*

* Exceptions:

(1) If you receive Emergency room services from a non-PPO provider or hospital within 24 hours of an accident, the Plan will pay 90% (Enhanced Plan) or 60% (Basic Plan) of the Covered Expense.

(2) If there are no PPO hospitals within a thirty (30) mile radius of your home, the higher PPO benefits will apply. Plan benefits will be based on the PPO Annual Deductible and the PPO Coinsurance level of 90% under the Enhanced Plan or 60% under the Basic Plan as long as you your admission is approved by the Medical Review Organization. If you do not have approval by the Medical Review Organization, benefits are reduced by 10%.

(3) In rare cases, there may be certain surgical procedures that require special facilities not available at a PPO hospital. In the event you should require such a procedure you must obtain prior approval from Anthem. If the Fund approves the procedure, your claim will be processed as if you used a PPO hospital even though the procedure is performed at a non-PPO hospital. Again, you must contact the Medical Review Organization for pre-admission certification.

ANNUAL OUT-OF-POCKET MAXIMUM

The annual out-of-pocket maximum is the most you pay toward Covered Expenses in a calendar year. This means that once you have reached your annual out-of-pocket maximum, the Plan pays 100% of the PPO Contract Rate, or the Allowable Expense for non-PPO Providers for the remainder of the calendar year.

Annual out-of-pocket maximums are shown in the following table:

Provider	Enhanced Plan	Basic Plan
PPO Provider	$1,500 per person $4,500 per family	$4,000 per person $8,000 per family
Non-PPO Provider	$5,000 per person $15,000 per family	Unlimited

The annual out-of-pocket maximum generally includes your coinsurance amount and the annual deductible. However, the following expenses do not apply to the annual out-of-pocket maximum:

- Expenses that are in excess of the Plan limits.
- Expenses not covered by the Plan.
- Expenses in excess of Covered Expenses (see page 64).
- The 10% penalty for Covered Expenses not approved by the Medical Review Organization.
- Copays on prescription drugs, which have separate out of pocket limits.

On January 1 of each year, your annual out-of-pocket maximum re-sets. You will again be responsible for your annual deductible and coinsurance, up to your out-of-pocket maximum.

UTILIZATION REVIEW

What Is Utilization Review?

The Trustees have contracted with a Medical Review Organization, Anthem Blue Cross, to review all proposed inpatient confinements (hospital, Skilled Nursing Facility, and other treatment facilities) When you use an Anthem Network Provider, this review process is automatic, and you don't need to do anything. When you use a provider who is not an Anthem Network Provider, you need to contact Anthem ***BEFORE*** you are admitted (except for Emergency admissions, as explained below). In addition, certain out-patient surgeries, diagnostic procedures and durable medical equipment also require prior authorization. By contacting Anthem Blue Cross for medical review, you will know ahead of time to what extent your medical expenses will be covered by the Plan. Anthem Blue Cross will review the proposed inpatient admission or outpatient procedure to determine if it is Medically Necessary.

You should contact Anthem Blue Cross as soon as you learn of a proposed inpatient stay, unless you use an Anthem Network Provider. For Emergency admissions, Anthem Blue Cross must be contacted within seventy-two (72) hours of the admission to ensure that continued confinement is necessary.

If inpatient utilization review is not obtained when required, the benefit payable will be reduced by 10%. Anthem Blue Cross may be contacted at (800) 274-7767.

Why Would A Proposed Inpatient Confinement Be Reviewed?

Anthem Blue Cross may determine that your inpatient stay is not Medically Necessary. Possible reasons for such a determination may include.

- in accordance with medically acceptable standards, your proposed surgery can be performed on an outpatient basis or at a surgical center;
- you are admitted to the Hospital a day prior to your surgery for tests which can be conducted on an outpatient basis prior to your admission;
- you are admitted on a Friday, Saturday or Sunday and your surgery is scheduled for the following Monday;
- your admission is for a longer period of time than is Medically Necessary for your condition; or
- your admission is for a surgical procedure which is not covered by the Plan.

How Does The Medical Review Program Work?

When you are advised that an inpatient admission may be necessary, you must inform your Doctor that your admission must be approved by Anthem Blue Cross ***prior*** to your admission. You or your Doctor must then contact Anthem Blue Cross to obtain the necessary approval. If possible, contact Anthem Blue Cross at least three business (3) days prior to your admission.

Medical review coordinators will make a complete review of the medical reasons for your inpatient admission. If there is any question concerning the Medical Necessity of your treatment or the proposed length of your admission, the review coordinator will refer the case to a Physician advisor. You, your Doctor and the facility are then notified whether the admission has been approved.

What If I Need To Stay In The Facility Longer Than Originally Approved?

All admissions, both Emergency and non-emergency, are subject to *concurrent review*. This process assures that only those patients with medical need remain as an inpatient and the treatment you receive is the appropriate treatment for your diagnosed condition.

At designated intervals, a review coordinator evaluates the medical information pertinent to your case. If necessary, the coordinator will approve any additional days you spend in the facility. Most case reviews do not require your involvement.

What If My Physician Disagrees?
If your proposed inpatient admission is denied, your Doctor can contact Anthem Blue Cross and request a second review. Your Doctor will be asked to submit additional medical evidence supporting his opinion. Anthem Blue Cross will then make its final determination.

What About Emergency Admissions?
If you are admitted to a facility in an Emergency, you do not need prior approval. However, Anthem Blue Cross must be contacted within seventy-two (72) hours after your Emergency admission in order to determine whether continued hospitalization is appropriate.

How Does Pre-Admission Certification Affect My Benefits?
If you are admitted to a facility without obtaining approval from Anthem Blue Cross, the benefits payable for the facility and medical expenses related to your inpatient stay will be reduced by 10%.

How Does Prior Authorization of Outpatient Services Affect My Benefits?
If prior authorization is not obtained for home health care, hospice care, and certain outpatient surgeries, x-ray and laboratory exams and durable medical equipment, benefits may be denied in whole or in part based on a retrospective medical review for Medical Necessity.

IMPORTANT: Anthem Blue Cross does not determine Plan benefits or eligibility. If you have any questions regarding benefits or eligibility, please contact the Fund Office.

CASE MANAGEMENT

In some instances, a patient's needs may be met as well or better by an alternative treatment in lieu of a Hospital confinement. Such alternatives could include home, hospice or nursing home care. In cases involving long-term disabling diseases or frequent re-admissions, Anthem Blue Cross, working with the patient's Physician, assesses whether alternative care is suitable for the individual patient and that the health care services are carried out in a manner that ensures continuity and quality of care.

The Plan will cover in full all expenses for alternative treatment plans that have been arranged and pre-approved by Anthem Blue Cross. If you do not choose to follow the alternative treatment plan approved through the case management program, normal Plan benefits will apply.

LIVEHEALTH ONLINE (TELEMEDICINE)

LiveHealth Online is a telemedicine program that gives you and your eligible dependents 24/7/365 access to quality medical care through video consultations. LiveHealth Online Doctors are U.S. board-certified Doctors and pediatricians who have practiced medicine with an average of fifteen (15) years' experience and who are specially trained for online consultations. With LiveHealth Online, you have the ability to access convenient quality health care without making a copay or being subject to the deductible. You should use LiveHealth Online for the following circumstances:

- Colds, sore throats, flu, allergies, infections or nutrition advice;
- If you are considering the emergency room or urgent care center for a non-emergency issue;
- If you are sick on vacation, a business trip, or away from home (domestic only);
- For short-term prescriptions or refills, when appropriate.

Please note that LiveHealth Online is not intended for medical emergencies. For life threatening medical emergencies go to a hospital emergency room, or an urgent care facility if your condition is not life threatening and immediate intervention is not necessary.

To access the program, simply log on to ***livehealthonline.com*** and follow the simple steps. You will need your Anthem Blue Cross ID number from your ID card when creating your account.

COVERED EXPENSES

The Plan provides benefits for the following services and supplies provided they are Medically Necessary for the treatment of a non-occupational illness or injury:

Ambulance

The Plan covers charges for professional ambulance service to or from the Hospital as a registered patient, or Emergency treatment within twenty-four (24) hours of an accident.

Chiropractic Treatment

The Plan covers chiropractic treatment as any other condition.

Diagnostic Imaging and Laboratory

The Plan covers x-ray, laboratory or other diagnostic examinations authorized by a licensed Doctor. Some procedures, such as MRI's and Angiograms, require prior authorization when you don't use an Anthem Network Provider; contact Anthem before you have these services performed.

Durable Medical Equipment and Supplies

The Plan covers the purchase or rental of durable medical equipment and supplies. Some items such as artificial limbs and eyes, artificial respirators and home oxygen require prior authorization. Other items such as surgical dressings, casts, splints, braces, crutches, wheelchairs, and hospital-type beds do not require prior authorization. Contact the Anthem for further information. In certain instances, the Plan will seek to rent the equipment with the rental fees applied to the purchase price.

Covered expenses are limited to the standard model of medically appropriate level of performance and quality for the diagnosed condition; deluxe or luxury equipment or items for convenience or comfort are not covered by the Plan.

Home Health Care

The Plan will reimburse charges incurred for Home Health Care if the care is authorized by Anthem.

Hospice Care

The Plan covers Hospice Care for those diagnosed with a life expectancy of fewer than twelve (12) months if the care is authorized by Anthem.

Hospital

The following benefits are payable for a confinement recommended by a Doctor for treatment of an illness or injury covered by the Plan. You must have your Hospital admission approved by Anthem before you are admitted when you do not use an Anthem Network Hospital.

- **Room and Board** – An amount not to exceed the Contract Rate at a PPO Hospital or the Hospital's normal semi-private daily room rate at a non-PPO Hospital. The Plan will not cover intensive care charges more than twice the Hospital's normal semi-private room rate in a non-PPO Hospital.

- **Hospital and Emergency Room Charges** – While admitted to the Hospital or for Emergency room treatment within twenty-four (24) hours of an accident, the Plan will pay for necessary services and supplies such as anesthetic, operating room, x-rays and laboratory expenses. Note: In the case of an Emergency hospital admission, you will not be penalized for using a non-PPO Hospital, until you can be transferred to a PPO facility, as described on page 24).

Mastectomy

If you or your Dependent receives benefits in connection with a mastectomy, you or your Dependent are also entitled to benefits for:

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

in a manner determined in consultation with the attending Physicians and the patient. Such coverage is subject to the annual deductible and coinsurance provisions under the Plan.

Maternity Benefits

Eligibility for maternity benefits is limited to the Employee and covered spouse. No maternity or delivery benefits are provided for Dependent children (except for certain preventative screening services mandated by the Affordable Care Act.) Maternity benefits are payable on the same basis as any other disability under the Plan. In accordance with federal law, Covered Expenses include maternity stays of forty-eight (48) hours after a normal birth and stays of ninety-six (96) hours after a Cesarean delivery. Any Hospital stay related to birth that is longer than these limits must be pre-authorized by Anthem Blue Cross. The attending Physician, after consultation with the mother, may release the mother before these time periods have expired.

- **Routine Nursery Care** is not a Covered Expense under the Plan. However, because PPO Hospitals do not charge for this benefit, you will not have as much out-of-pocket expense if your child is delivered at a PPO Hospital.
- **Midwifery Benefit** – The nurse-midwife must have a current "certificate of nurse-midwife" issued by the State of California Board of Registered Nursing at the time the services are rendered. The Out-of-Network Midwife benefit is limited to $750.

Mental Health Services

The Plan covers treatment of a mental health condition as follows:

- Inpatient Hospital or treatment facility expenses are covered in the same manner as for any other illness. All inpatient admissions are subject to pre-authorization (see page 27).
- Outpatient expenses are paid in the same manner as any other illness
- Outpatient prescription drugs for mental health conditions are payable the same as for any other illness, as outlined under the Prescription Drug Benefit (see page 38).

Nursing Services

The Plan will cover charges for medically necessary nursing services provided by a nurse, who is operating within licensing guidelines, does not ordinarily reside in your home, and is not a member of your immediate family.

Organ Transplant Benefit

The Plan covers Approved Charges for human organ and tissue transplant services, including solid organ and bone marrow/stem cell procedures. This coverage is subject to the following:

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogenic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart-lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures are also covered for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO) ventricular assist device (VAD) and intra-aortic balloon pump (IABP) are also covered.

All transplant services and related specialty care services are covered when approved by Anthem Blue Cross. Anthem's Centers of Excellence facilities are encouraged, but not mandatory.

Coverage for organ procurement costs is limited to costs directly related to procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary removal of an organ and transportation of a live donor. Compatibility testing undertaken prior to procurement is covered when Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Advance cellular therapy, including but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, is covered.

Transportation Benefits and Specialty Care

Expenses for travel incurred by you in connection with an approved organ/tissue transplant procedure are covered, subject to the following conditions and limitations:

- Transplant and related specialty care travel expenses are not available for cornea transplants.
- Benefits for transportation, lodging and meals are available to the recipient of a preapproved organ/tissue transplant. There is a daily limit of $200 for lodging, and reimbursement for all transportation, lodging and meals for a covered Organ Transplant Procedure are limited to $5,000.
- Travel expenses for the person receiving the transplant will include charges for transportation to and from the designated Centers of Excellence Transplant facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed a coach class fare for air travel.

These benefits for transplant services and related specialty care, and for transplant and related specialty care travel services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan should cover all donor costs. Transplant travel expenses are subject the Plan deductible and will be applied to the calendar year out-of-pocket maximum.

Exclusions Specific to the Organ Transplant Benefit:
No benefits will be payable by the Plan for the following:

1. Any organ transplant performed at a facility not approved in advance by Anthem Blue Cross pre-authorization review.

2. Any service or supply which is excluded from coverage in the Exclusions sections of this booklet beginning on pages 32 and 35.

3. Animal and/or mechanical organs excepting pumps and valves.

4. Any expense incurred for which you would not legally have to pay if you were not covered by this Plan.

5. Any injury or sickness due to employment.

6. Custodial Care.

7. Donor charges when the transplant recipient is not covered by the Plan.

Physical/Occupational/Speech/ABA Therapy

The Plan covers expenses incurred for Medically Necessary physical therapy, occupational therapy, speech therapy, and applied behavioral analysis therapy for autism in the same manner as any other illness.

Physicians' Fees

Treatment by a Doctor at home, in the Hospital, in a Doctor's office and through telehealth visit are covered by the Plan. LiveHealth Online, a telemedicine program is also available to access medical care through a telephone, cell phone or computer. See page 28 for more information.

Preventive Care Services

For services performed by a PPO Provider, the Plan pays 100% of the Covered Expense and the annual medical deductible does not apply.

Preventive Care Services performed by a non-PPO Provider are not covered, the Plan pays 70% (40% for the Basic Plan) of Covered Expenses and the annual medical deductible does not apply.

The following Preventive Care Services are covered:

- Preventive care services and screenings per the US Preventive Services Task Force (USPSTF) A and B recommendations. Covered procedures include such services as blood pressure and cholesterol screening, various cancer and sexually transmitted infection screenings, as well as counseling in defined areas. A complete list of these services and screenings can be reviewed at ***www.uspreventiveservicestaskforce.ort/recommendations***.

- Routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunizations schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at ***www.cdc.gov/vacines***.

- Preventive care services and screenings for infants, children and adolescents as recommended by the Health Resources and Services Administration (HRSA).

- Preventive care services and screenings for women recommended by the Health Resources and Services Administration (HRSA). A complete list of these services can be reviewed at ***www.hrsa.gov/womensguidelines***.

If you have any questions about what is covered under the Plan's preventive care benefit, please contact the Fund Office.

Routine Physical Examination

See Preventive Care Services above.

Skilled Nursing Facility

Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

It is accredited by The Joint Commission (TJC) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility.

- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an injury or illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician.

- It provides services under the supervision of Physicians.

- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed registered nurse on duty at all times.

- It maintains a daily medical record of each patient who is under the care of a licensed Physician.

- It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill.

- It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Surgical Expenses

The Plan will cover fees charged by a licensed Physician or surgeon for a surgical operation performed in or out of a Hospital as a result of an accident or illness.

- **Assistant Surgeon's Fees** – When the services of an Anthem Network Surgeon are not utilized, the Plan will pay up to 20% of the operating surgeon's rate toward the assistant surgeon's charges.

- **Anesthesia** – Administration of anesthetics will include the customary pre-operative and post-operative visits of the Anesthetist, the administration of anesthetics and the administration of fluids or bloods incident to the anesthesia and surgery. Payments will be made for these services, provided the Anesthetist (who is not the operating surgeon or assistant surgeon) remains in constant attendance during your surgery for the sole purpose of performing such services.

- **Outpatient Surgery** – Surgery performed on an outpatient basis in a Hospital, a state licensed or Medicare approved facility or at your Doctor's office is covered as any other medical procedure. Some outpatient surgeries require prior authorization; contact the Medical Review Organization for additional information.

Well Baby Care
See Preventive Care Services on page 33.

Obesity Treatment
Clinically severe (morbid) obesity, which is defined as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities.

If you do not find a specific type of treatment listed as a covered benefit or if a treatment is not shown as excluded in the list below, call the Fund Office to determine if that treatment is covered under the Plan.

EXCLUSIONS AND LIMITATIONS
The Plan will not pay medical benefits for expenses incurred for any of the following:

1. Any procedure, equipment, treatment, drug or medication that is not Medically Necessary;

2. Custodial Care;

3. Any injury or illness for which the Participant is not under the regular care of a Doctor;

4. Eyeglasses, eye refractions or routine eye examinations (routine vision care is covered under a separate program see page 50);

5. Radial keratotomy, Keratomileusis or Lasik surgery;

6. Hearing aids;

7. Cosmetic surgery, except as (i) required under the Women's Health and Cancer Rights Act, (ii) for expenses incurred after an accident and that are necessary for the repair or alleviation of damage resulting from that accident (a lifetime maximum of $10,000 applies for cosmetic surgery in connection with accidents), and (iii) for Medically Necessary treatment for gender dysphoria to the extent required under Section 1557 of the Patient Protection and Affordable Care Act;

8. Medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity, as well as weight loss programs or treatments, whether or not they are prescribed by a Doctor or under medical supervision. (Obesity screening and counseling services are covered to the extent required by law as a preventive care service.)

9. Dental services (including x-rays), except for expense incurred after an accident and necessary for the repair or alleviation of damage to teeth resulting from an accident (routine dental services are provided under the Dental Benefit Program, starting on page 45);

10. Any injury covered by workers' compensation or occupational safety and health laws;

11. Any injury or illness arising from or sustained in the course of any occupation or employment for compensation, profit or gain;

12. Expenses incurred (a) during confinement in a Hospital owned or operated by the United States Government or any of its agencies, or for any medical services, supplies or treatment furnished by or for such Government or agency, except as required by federal law, or (b) during confinement in a Hospital owned or operated by a state or any of its political subdivisions unless there is an unconditional requirement to pay such charges without regard to any rights against others, contractual or otherwise;

13. Charges in connection with injuries or illnesses sustained while committing or attempting to commit a felony;

14. Charges for any services provided by a parent, sibling, spouse or any member of the Employee's or Dependent's household, except for charges for out-of-pocket expenses incurred for such individuals;

15. Any services and / or supplies for which the participant is not required to pay or has no obligation to pay or for which no charges are made;

16. Reversal of a previous vasectomy or tubal ligation;

17. Expenses related to inducement of pregnancy, including in vitro fertilization, artificial insemination and other direct attempts to induce pregnancy;

18. Experimental or investigational procedures, except as required under the Affordable Care Act for clinical trials;

19. any expense incurred arising from an organ transplant except as provided under the organ transplant benefit section on page 31;

20. Prescription drugs when not confined in a Hospital (outpatient Prescription Drugs are covered under a separate prescription drug program – see Prescription Drug Benefits, starting on page 38);

21. Vitamins, except for Medically Necessary vitamins prescribed by a Doctor that are required to be covered by the Affordable Care Act;

22. Private Hospital rooms unless isolation is a certified Medical Necessity by the Review Organization;

23. Any services or appliances related to treatment of temporomandibular joint pain or syndrome (TMJ);

24. Expenses related to male erectile dysfunction;

25. Acupuncture or biofeedback treatment;

26. Alcohol and drug rehabilitation (benefits for these are provided separately under the Teamsters Assistance Program (TAP), starting on page 37);

27. Expenses in connection with a Dependent child's pregnancy, except as required by law;

28. Routine foot care such as callus or corn paring, toenail trimming or for the diagnosis or treatment of weak, strained, unstable or flat fee or for any tarsalgia, metatarsalgia or bunions (except for surgeries which involve the exposure of bones, tendons or ligaments) or for orthotic devices used in connection with the treatment of such chronic foot conditions;

29. Environmental equipment; and

SUBSTANCE ABUSE BENEFITS
THROUGH TEAMSTERS ASSISTANCE PROGRAM (TAP)

Substance abuse benefits for all Plan participants (in both the PPO Medical Plan and Kaiser HMO Plan) are provided through the Teamsters Assistance Program (TAP).

WHAT IS THE TEAMSTERS ASSISTANCE PROGRAM (TAP)?

TAP is a consultation and referral program established to provide assessment, referral for treatment and counseling for substance abuse problems.

If you live in the San Francisco Bay Area, contact TAP by calling (510) 562-3600. If you are outside the San Francisco Bay Area, call (800) 253-TEAM. The TAP counselor will either schedule an appointment for you or direct you to the most appropriate health care professional in their pre-screened network for additional assistance or treatment.

If you are referred to another resource, the TAP counselor will monitor the services you receive to be sure you are getting the help you need.

After you have completed a treatment or rehabilitation program, your TAP counselor will work with your primary counselor to be sure you are connected with all of the Teamsters' support services including aftercare meetings, fellowship activities, volunteer support and special education classes.

WHAT IS COVERED UNDER THE PLAN?

Treatment may consist of inpatient treatment, outpatient care or a combination of both.

After you have met the annual medical plan deductible (see page 25), the Plan pays the following coinsurance amounts:

Provider	Enhanced Plan	Basic Plan
TAP Provider	90%	60%
Non-TAP Provider	70%	40%

Coinsurance amounts are based on:

- TAP Contract Rate for services provided by TAP providers.
- Covered Expenses for services provided by a non-TAP provider.

Non-Emergency inpatient care must be pre-authorized by TAP. If pre-authorization is not obtained, the above percentages will be reduced by 10%.

Note: If you are enrolled in the Kaiser HMO Plan, you may access services from TAP, however, following diagnosis and referral, any detoxification or outpatient individual therapy would be provided through Kaiser. Also, outpatient individual therapy provided by Kaiser is subject to a $25 copay per visit.

PRESCRIPTION DRUG PROGRAM

Participants that are enrolled in either the PPO Medical Plan or the Kaiser HMO Plan are eligible for the prescription drug benefits described in this section.

Prescription drug coverage is available in two convenient ways; either through the Retail Pharmacy Card Program or the Mail Order Program. Both programs are administered by OptumRx. You can contact OptumRx directly for information about participating pharmacies, mail-order prescriptions and to order refills:

- The toll-free Customer Service number is (800) 797-9791. You can call Customer Service 24 hours a day, 7 days a week.

- The Optum Rx website is ***www.optumrx.com***.

FORMULARY

Your prescription benefit uses a list of preferred drugs called a formulary. These drugs have been selected by a panel of Physicians and pharmacists based on therapeutic effectiveness and favorable pricing arrangements, including volume rebates. The formulary is available on the OptumRx website at ***www.optumrx.com*** or from the Fund Office. Compliance with the formulary is voluntary but will affect the amount of your copay or reimbursement. Please share this list with your Physician during your visit; use of formulary drugs can result in lower overall costs to the Fund – and to you.

Certain non-essential medications are not covered by your prescription drug benefit since they contain a similar chemical make up as existing more effective drugs, and therefore increase cost without providing additional value. Please note that you will pay the full cost of these non-essential medications even if you received prior authorization in the past. Please talk to your Doctor to discuss alternative medications.

MAINTENANCE PRESCRIPTION DRUGS

Maintenance drugs are certain designated medications used to treat chronic or long-term conditions such as diabetes, arthritis, heart conditions, high cholesterol, digestive, asthma and high blood pressure.

Maintenance prescription drugs written for a 34-day supply can be filled at a retail pharmacy. In addition, maintenance prescriptions written in excess of a 34-day supply can be purchased at a participating retail pharmacy or through the mail order program as described below.

ANNUAL DEDUCTIBLE

The deductible is the amount you must pay toward covered prescription drug expenses each calendar year before the Plan pays benefits. The deductible amounts differ by the Plan you are covered under, as shown in the following table.

Covered	Enhanced PPO Kaiser HMO	Basic PPO
Per Person	$0	$1,500
Per Family	$0	$3,000

Prescription drugs filled at retail, mail order and specialty pharmacies apply toward the annual deductible.

RETAIL PHARMACY CARD PROGRAM

The Retail Pharmacy Card Program provides a 34-day supply of medication per prescription or refill at a pharmacy. Also, for certain maintenance prescription drugs, a 100-day supply may also be available.

This program offers you the convenience of local participating pharmacies for your short-term and immediate prescription drug needs. You can use a participating pharmacy in the OptumRx network or you may purchase your drugs at any pharmacy, the choice is yours each time you need a prescription filled.

Under this program, the following copays apply.

Type of Prescription Drug	Enhanced PPO Kaiser HMO	Basic PPO
Generic	$5 copay	30% coinsurance
Formulary brand	$20 copay	40% coinsurance
Non-formulary brand	$45 copay	40% coinsurance
Specialty Injectables	10% copay, not to exceed $100 per prescription and subject to preauthorization. Only available at OptumRx participating pharmacies.	

Note: Non-injectable specialty drugs are subject to the standard copays shown above.

When you use an OptumRx network participating pharmacy, you have the advantage of receiving discounted prices and there are no claim forms to file. At participating pharmacies, the pharmacist will use a computerized system to confirm your eligibility for benefits and determine the discounted cost of your prescription. Simply present your prescription card and make your appropriate copay. Your copay depends on whether the prescription is for a generic or brand-name drug. Copays are shown in the table above.

If you use a non-participating pharmacy, you will have to pay the full cost of the prescription and file a claim with OptumRx to be reimbursed for the cost minus the copay amount shown in the table above. Claim forms may be obtained from OptumRx or the Fund Office. A claim form must be submitted with copies of the prescription receipt (not cash register receipts) and sent to the address on the form.

MAIL ORDER PROGRAM

The Mail Order Program provides up to a 90-day supply of medication per prescription or refill.

The Mail Order Program is designed for maintenance medications for ongoing or chronic conditions. Your copay depends on whether the prescription is for a generic or brand-name drug and whether it is on the Formulary. The copay amounts are shown in the following table.

Type of Prescription Drug	Enhanced PPO Kaiser HMO	Basic PPO
Generic	$10 copay	30% coinsurance
Formulary brand	$40 copay	40% coinsurance
Non-formulary brand	$90 copay	40% coinsurance

How to Use the Mail Order Program

To use the mail order program for the first time, complete a patient profile questionnaire. The questionnaire asks for information about your medical history, blood type, allergies and any other drugs you are taking (prescription and over-the-counter). OptumRx keeps this information and checks it every time you send a prescription. You may update your profile as you like by including any health condition changes with your prescription. Follow these steps:

- Obtain an envelope (from OptumRx, the Fund Office or your Local Union). Complete the information requested on the envelope, including your Physician's name. OptumRx automatically fills your prescriptions with a generic alternative whenever possible.

- If you are getting a new prescription filled, have your Physician prescribe up to a 90-day supply of the maintenance drug with the appropriate number of refills. If your Physician specifies a brand-name drug and writes "Dispense as Written" (DAW) on the prescription, the pharmacist will fill your prescription with the brand-name drug rather than filling it with a generic drug. However, the pharmacist may call your Physician to request approval of filling your prescription with a generic drug.

- If you are requesting a refill, you should request your refill at least two weeks before your prescription runs out. With each prescription, OptumRx sends a postage-paid envelope (for your future use) and a notice showing how many refills you have left. Be sure to contact your Physician when you request your last refill from OptumRx.

- Send your prescription (and questionnaire if it's your first order) or request for a refill and the appropriate copayment in the postage-paid envelope to OptumRx. You can pay by check, money order, MasterCard or Visa. If use a credit card, include the card number and expiration date. DO NOT SEND CASH.

Within three weeks after ordering a new prescription or two weeks on a refill, your prescription will arrive, at the address you indicated on the envelope, by United Parcel Service (UPS) or U.S. Mail.

OPTUM SPECIALTY PHARMACY

Some specialty medications, such as those used to treat Hepatitis C and Multiple Sclerosis, will be filled by Optum Specialty Pharmacy (you may receive one fill at a retail pharmacy). This program not only supplies the prescribed medication and related supplies, such as needles and syringes, but also provides clinical support to you to help improve compliance as well as provide convenient delivery. If you are currently being prescribed a medication that will be filled as part of this program, you will receive more information under separate cover.

Injectable medications from the Specialty Pharmacy have a 10% copay, up to a maximum of $100 per prescription.

To begin using Optum Specialty Pharmacy, you or your Physician can call (877) 839-7045.

PRESCRIPTION DRUG ANNUAL OUT-OF-POCKET MAXIMUM

The Plan has a maximum amount you will pay for prescription drugs each year. Once you have reached this Prescription Drug Annual Out-of-Pocket Maximum the Plan pays 100% for most covered prescription drugs for the remainder of the calendar year.

Covered	Kaiser HMO	Enhanced PPO	Basic PPO
Each Person	$6,400	$6,400	$3,900
Each Family	$12,800	$11,300	$7,800

Prescription drugs filled at retail, mail order and specialty pharmacies apply to the out-of-pocket maximum.

PREVENTIVE CARE PRESCRIPTION DRUGS

In accordance with Federal law, the Plan covers preventive care drugs at 100% with no copay when purchased at an OptumRx network participating pharmacy. Preventive care drugs may include aspirin, tobacco cessation drugs, contraceptive drugs and devices, vitamin and mineral supplements as well as other products. Gender age and/or other limits apply. Please note that over the counter (OTC) drugs require a prescription to be covered and quantity limits may apply to some drugs.

A complete and up-to-date list of preventive care drugs can be found at ***www.hhs.gov/healthcare***. This list may be subject to change.

ROUTINE IMMUNIZATIONS

Routine immunizations are available at many retail pharmacies.

The Plan provides benefits for routine immunizations at a $0 copay when received at an OptumRx network participating pharmacy. Included immunizations are those recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at ***www.cdc.gov/vaccines***. Not all ACIP recommended immunizations are available at OptumRx network participating pharmacies.

STEP THERAPY

For certain prescription therapies, participants and their Physicians will be required to first use lower cost brand or generic equivalents when appropriate, as a first step. If, after using the lower cost brand or generic equivalent, you and your Physician still require the higher cost treatment, coverage will be provided under this program. However, the initial prescription must be this step prescription. This program is intended to provide you with coverage that is most effective, both on a treatment and financial basis.

PRIOR AUTHORIZATION

Under Prior Authorization, prescriptions for certain medications require coverage review before the Plan will cover the medication. If your Doctor prescribes one of these mediations, your pharmacist or your Doctor must call OptumRx customer service. OptumRx will work with your Doctor(s) office to get the information for the coverage review. If your Doctor does not return the information we ask for, the Prior Authorization request will be denied. OptumRx will notify you and your Doctor if the request is denied.

The benefits of Prior Authorization include:

- Promoting safe use of medications.
- Helps manage expensive and/or highly used drug categories.

Here are some examples of drug classes that require a prior authorization. This is not a complete list: Blood Formation Agents, Growth Hormone, Hepatitis C, Psoriasis, Pulmonary Hypertension, Rheumatoid

Arthritis, Testosterone Replacement, Sleep Disorder, Weight Loss and select pain medications. Some medications may require prior authorization based on age, gender or quantity limits.

QUANTITY LIMIT

A Quantity Limit is the greatest amount of a medication that is allowed to be dispensed for each prescription or over a certain period of time. The benefits of Quantity Limits include:

- Prevents over prescribing or having to take medication longer than needed.
- Manage unsafe medication use.
- Reduces risks of misuse and abuse of certain medications.

Here are some examples of drug classes that are subject to Quantity Limits. This is not a complete list: Anti-fungal, Anti-Emetic, Erectile Dysfunction, Hypnotic, Migraine and Smoking Cessation medications.

When you present a prescription for a drug that requires any of the above edits, the OptumRx claims system automatically searches the member's medical and drug profile to determine if the drug meets the required criteria. If the drug does not meet the requirement, the dispensing pharmacist receives a system message and the pharmacist may discuss the appropriateness of the requested medication with you and contact the prescribing Physician or the OptumRx customer service department.

COVERED DRUGS

All drugs which must be dispensed under federal or state law upon the written prescription of a Doctor are covered under this Program, except as described under "Exclusions."

In addition, the following drugs that normally do not require the prescription of a Doctor are covered if they are prescribed in writing by a Doctor:

- Insulin

- Diabetic Supplies, which shall include:

  - insulin syringe
  - needles (2)
  - disposable needles (60-day supply)
  - sugar test tablets
  - sugar test tape
  - acetone test tablets
  - benedicts solution or equivalent

- Compounded dermatological preparations (ointments and lotions which must be prepared by a pharmacist in accordance with the prescription of a Physician).

  Medically Necessary vitamins that are required to be covered under the Affordable Care Act.

- Cough Mixtures:

  - Elixir Terpin Hydrate, N.F.

- Anti-Acids:

  - Aluminum Hydroxide
  - Aluminum Hydroxide with Magnesium Trisilicate
  - Aluminum and Magnesium Hydroxide Gel Calcium Carbonate
  - Magnesium Carbonate Suspension
  - Dihydroxyaluminum Aminoacetate

PRESCRIPTION DRUG PLAN EXCLUSIONS

1. Non-federal legend drugs or medication procured or procurable, except as noted above, without a Doctor's written prescription.

2. Drugs or medication that are not Medically Necessary.

3. Nose drops, except those which require a Doctor's written prescription.

4. Contraceptives, except for therapeutic purposes confirmed by a Doctor or as required to be covered by law as a preventive care service (see page 33).

5. Immunization agents.

6. Appliances or prosthetics, respiratory therapy supplies, support garments, and other non-medical supplies.

7. Any non-drug item.

8. Drugs necessary for illness or injury covered by any workers' compensation or occupational disease law.

9. Drugs prescribed during Hospital admission and payable under the Kaiser HMO Plan or the PPO Medical Plan.

10. Drugs that are Experimental.

11. Drugs that do not have the full approval of the U.S. Food and Drug Administration (FDA) for the condition for which they have been prescribed.

12. Appetite suppressants or weight loss agents, except as required by law.

13. Blood and blood plasma. These items may be covered under medical benefits.

14. Drugs for which no charge is made.

15. Drugs that are lost or stolen.

16. Drugs prescribed for accidental bodily injury or sickness that occurs while in the armed services and determined by the Secretary of Veterans' Affairs to be service-connected.

17. Hair treatment prescriptions, including Rogaine and Minoxidil.

18. Cosmetic, health or beauty aids except for Medically Necessary treatment for gender dysphoria to the extent required under Section 1557 of the Patient Protection and Affordable Care Act.

19. Prescription nicotine products or smoking deterrents, including Nicorette gum, unless required by law.

20. Fertility drugs.

21. Drugs related to sexual dysfunction.

22. Drugs prescribed for conditions or treatments not covered under the Fund's medical benefits.

23. Growth hormones for the purpose of increasing stature.

24. Over-the-counter (OTC) drugs, vitamins and supplements, unless required by law.

NOTICE ABOUT MEDICARE PART D

When you become eligible for Medicare you become eligible for Medicare's prescription drug benefit – "Medicare Part D." You may hear from private companies hoping to enroll you in their Medicare Part D program. **Your Northern California Soft Drink Industry Health and Welfare Trust Fund prescription drug coverage provides better coverage at less cost to you than Medicare Part D. The federal Centers for Medicare and Medicaid Services (CMS) will consider your coverage under the Fund to be "creditable," which means that the Fund expects to pay as much or more for your prescription drug coverage than Medicare would pay if you enrolled in Part D. THEREFORE, WHILE YOU ARE COVERED BY THE FUND YOU SHOULD NOT ENROLL IN MEDICARE PART D WHEN YOU RECEIVE MEDICARE'S APPLICATION.**

Medicare expects you to enroll in Part D as soon as you become eligible, and charges higher premiums to late enrollees, *unless you are already covered by "creditable" prescription drug coverage like that of the Fund.* Because your coverage under the Fund is creditable, if you decide to enroll in Part D in the future – because, for example, your Fund coverage terminates – you will not be penalized for late enrollment in Part D if you enroll in Medicare Part D within 63 days of your loss of coverage.

Visit ***www.medicare.gov*** or call 800-MEDICARE (800-633-4227) for more information about Medicare Part D.

DENTAL CARE PROGRAM

Participants of the PPO Medical Plan and the Kaiser HMO Plan are eligible for dental benefits under one of the two following plans:

- **UnitedHealthcare Dental Option**
  (UnitedHealthcare is a prepaid dental plan that works like an HMO.)

- **Anthem Dental PPO Plan Option**

Newly hired Employees and their Dependents are limited to the UnitedHealthcare Dental Option for the first three (3) years of coverage in the Fund.

UNITEDHEALTHCARE DENTAL PLAN

If you are a new enrollee, you must enroll in the UnitedHealthcare Dental Plan for your first thirty-six months of coverage by the Fund. After thirty-six months of coverage, you may enroll in the Anthem Dental PPO Plan Option in accordance with the rolling enrollment provisions of the Plan (see page 13). **A copy of the UnitedHealthcare Dental *Explanation of Coverage* can be obtained from the Fund Office**.

You **must** use a UnitedHealthcare Dentist to receive benefits.

100% of your dental care is covered except for those services that require a co-payment. There is no deductible and there is no annual maximum limit. However, you must obtain pre-authorization for orthodontic services by calling (800) 999-3367. A copy of the UnitedHealthcare Dental Schedule of co-payments will be provided with the package of information you will receive upon initial enrollment.

Orthodontic Benefits

Eligibility for orthodontic care under the UnitedHealthcare Dental Plan is limited to dependent children under the age of 26 and only if the Employee-parent has been eligible for benefits under the Dental Care Program during the nine months immediately preceding the month in which orthodontic treatment is started. The date on which banding is done will be considered the date treatment has begun. Treatment *must* be provided by a UnitedHealthcare Orthodontist, and you must obtain pre-authorization for orthodontic benefits by calling (800) 999-3367.

Orthodontic benefits are paid according to the following schedule:

Start-Up Fees	$350
Retainers (1 set)	$150
Payment Schedule	$250 (at inception of care, i.e. placement of bands)
	Then $50 per month for 10 months

ANTHEM DENTAL PPO PLAN

The Fund has contracted with a preferred provider organization (PPO) through Anthem Blue Cross (Anthem) that offers a network of Preferred (PPO) Dental Providers that have agreed to provide you and your Dependents with covered dental services at discounted fees. These discounted fees reduce the cost to you and the Fund and your out-of-pocket expenses are less when you use PPO Providers. **A copy of the Anthem Dental Certificate *of Coverage* can be obtained from the Fund Office. The following is a general summary of your Anthem benefits. The terms of the Anthem contract govern this benefit and if there are any differences between this summary and the benefits set forth in that contract, the terms of the Anthem contract will prevail.**

	Anthem PPO Dentists	**Non-PPO Dentists**
Annual deductible	None	None
Maximum annual benefit Per Person	$2,000	$2,000
Covered charges are based on:	Anthem Contract Fees	Allowable Charges
Benefit:		
Diagnostic and preventive Periodic oral exam 2 per 12 months Teeth cleaning 2 per 12 months Bitewing x-rays 1 set per 12 months Full mouth x-ray 1 per 12 months Fluoride application 1 per 12 months through age 14 Sealants 1 per 48 months through age 14	100%	85%
Basic restorative Space maintainer 1 per lifetime through age 18—posterior teeth Fillings composite anterior, amalgam posterior 1 per tooth per 24 months	85%	70%
Endodontics Non-surgical Surgical	85%	70%
Periodontics Non-surgical Periodontal maintenance 4 per 12 months with teeth cleaning Scaling/root planing 1 per quadrant per 24 months Surgical (osseous, gingivectomy graft procedures) 1 per quadrant per 36 months	85%	70%
Oral surgery Simple Complex	85%	70%
Major (restorative) services and prosthodontics Crowns, veneers, dentures and bridges 1 per tooth per 60 months Repairs and adjustments Crown, denture, bridge repair 1 per 12 months, 6 months after placement Denture and bridge adjustments 2 per 12 months, 6 months after placement	70%	70%

Cost Advantage of Using an Anthem Network Provider
When you use an Anthem network provider you only pay the difference between the Contract Rate and the benefit percentage. When you go out of network you pay the difference between the Allowable Expense and the benefit percentage plus any amount the Dentist may charge above Allowable Expense. The example below shows how your out-of-pocket costs are affected.

	Anthem PPO Dentist	**Non-PPO Dentist**
Charge for a filling	$200	$200
Non-PPO Allowable Charge		$160
Anthem discounted fee	$120	
Benefit percentage (basic restorative)	85%	70%
Benefit paid (85%of $120/70% of $160)	$102	$112
Your out-of-pocket cost:		
Difference between PPO and non-PPO Allowable Expenses		
15% of $120	$18	
30% of $160		$48
Amount of the non-PPO Dentist's charge that is not covered		$40
Total out-of-pocket cost	$18	$88

Besides a lower out-of-pocket cost, the advantage of using a PPO Dentists is that your annual maximum benefit of $2,000 stretches further because services cost less.

Orthodontic Benefits

Eligibility for orthodontic care under the Anthem Dental PPO Plan is limited to dependent children through age 18. The date on which banding is done will be considered the date treatment begins. Other key provisions of this benefit are:

- Lifetime benefit maximum — $1,500
- Benefit:
  - In network — 70% of Anthem's Contract Rate
  - Out-of-network — 70% of Allowable Charges
- Pre-Treatment Estimate — Contact Anthem at (844) 729-1565

Anthem will not make payments for orthodontic services rendered prior to your eligibility date for orthodontic benefits. Only one comprehensive orthodontic treatment is covered per lifetime.

If you have been a member of the Anthem Dental PPO Plan and elect to enroll in the UnitedHealthcare Dental Plan during your rolling enrollment period while you are already in the process of orthodontic treatment, the balance of the orthodontic benefits available to your child will be paid under the Anthem Dental PPO Plan.

Termination During Orthodontic Treatment Plan
If the orthodontic treatment plan is terminated for any reason before its completion, the treatment plan is not finished when this Plan terminates or if your eligibility under this Plan ends, the obligation of the Trust Fund will cease with payment up to the last treatment date, the date the Plan terminates or the date your eligibility ends, whichever occurs first.

Administration

Anthem will provide full claims administration for all of your dental claims (PPO and non-PPO), and respond to any inquiries you may have regarding benefits, a pending claim, or to locate a preferred dental provider in your area. You can also locate a provider by visiting ***www.anthem.com/ca***. The Fund Office will continue to verify your eligibility and respond to questions regarding your other benefits. For any questions regarding your claim or benefits, please contact Anthem at **(844) 729-1565**. *New Hires are limited to the UnitedHealthcare Dental Plan for the first three years of coverage.*

Exclusions and Limitations

No payment shall be made under the Anthem Dental PPO Plan for expenses incurred for any of the following:

1. Dental or orthodontic services furnished by a Hospital or facility operated by the U.S. Government, or any authorized agency thereof, or furnished at the expense of such government or agency.

2. Any procedure covered by workers' compensation or occupational disease law.

3. More than one comprehensive orthodontic treatment per lifetime.

4. Any charges made by the Dentist for the replacement or repair of an appliance that is lost or broken.

5. Any dental expense incurred in connection with any dental procedure started after you or your Dependent has lost eligibility under the Plan.

6. Any orthodontic service provided on or after the date of termination of the Plan.

7. Any dental treatment for strictly cosmetic or esthetic purposes.

8. More than two (2) periodic oral exam every twelve (12) months.

9. More than one (1) set of full month x-rays per twelve (12) months.

10. More than two (2) prophylaxis every twelve (12) months.

11. More than one (1) fluoride treatment per twelve (12) months (through age 14).

12. More than two (2) set of occlusal x-rays every twelve (12) months.

13. More than one (1) replacement of prosthetic appliances obtained every 60 months.

14. General anesthetics including intravenous and inhalation sedation. If the use of general anesthesia is elected by the patient, the charges for its use will be the responsibility of the patient.

15. Surgical procedures incidental to orthodontic treatment (including extraction of teeth, procedures related to cleft palate, micrognathia or macrognathis, and orthodontic treatment of cleft palate patients).

16. Cephalometric x-rays, dental x-rays, tracings and photographs, and study models.

17. Changes in treatment necessitated by an accident of any kind.

18. Drugs dispensed in the dental office (written prescriptions are covered).

19. Any Hospital charges of any kind (although these may be covered under the medical plan).

20. Orthodontic treatment of patients with severe medical disabilities which may prevent acceptable correction of the existing malocculasion.

21. Treatment plans that in the opinion of Anthem are unlikely to produce an acceptable correction of the existing malocculasion.

22. Orthodontic, surgical and dental treatment which exceeds Usual, Customary and Reasonable orthodontic treatment.

23. Treatment which is Experimental.

24. Any services or appliances related to treatment of temporomandibular joint pain or syndrome (TMJ).

25. Any treatment on primary teeth that are exfoliating or are soon to exfoliate.

26. Any service not needed to prevent and eliminate oral disease or to maintain or restore function.

27. Any treatment performed by someone other than a licensed Dentist, except for charges for dental prophylaxis (cleaning and scaling) performed by a licensed dental hygienist.

28. Full mouth rehabilitation or reconstruction.

In the event you require dental care that is not specifically excluded above but for which no procedure is listed in the Schedule of Allowances for Dental Procedures, you should contact the Fund Office for further information.

If your Dependent is covered by another dental plan as an Employee, this Fund shall pay the difference between the amount paid by the other plan and 100% of the total charges. In no event will the allowance exceed the maximum amount payable as stated in the Schedule of Allowances of Dental Procedures.

If there is any conflict between this SPD and the Certificate of Coverage available from Anthem, the provisions contained in the Certificate of Coverage supersede.

VISION CARE BENEFITS

This section applies only to Employees who are enrolled in the PPO Medical Plan. If you are enrolled in the Kaiser HMO Plan, eye exams, lenses and frames are provided by Kaiser. Kaiser HMO participants can also obtain lenses and frames from VSP, but the cost for the lenses and frames will only be reimbursed under the Non-VSP Provider Schedule.

If you are enrolled in the PPO Medical Plan, the Fund has an agreement with VSP Vision Care to provide vision benefits to you and your eligible dependents. Under this agreement, you can use any provider you wish. However, if you use a VSP provider, you may receive higher benefits and they automatically file claims for you.

SCHEDULE OF BENEFITS

The following table summarizes your vision benefits, both in and out of network:

Covered Expense	If You See a VSP Network Provider...	If You See a Non-VSP Provider...
Eye Exam (once every 12 months from your last date of service)	Paid in full	Up to $50
Lenses (one pair every 12 months from your last date of service)		
• Single vision	Paid in full[1]	Up to $50
• Lined bifocal	Paid in full[1]	Up to $75
• Lined trifocal	Paid in full[1]	Up to $100
• Lenticular	Paid in full[1]	Up to $125
Frames (once every 24 months from your last date of service)	Paid up to $120[2]	Up to $70
Contacts instead of lenses and frames (once every 12 months from your last date of service)		
• Necessary[3]	Paid in full	Up to $210
• Cosmetic	Paid up to $130 for contacts and contact lens exam (fitting and evaluation)	Up to $105
Lens Options (once every 12 months from your last date of service)		
Standard progressive lenses	$50 copay	Up to $75
Premium progressive lenses	$80-$90 copay	Up to $75
Custom progressive lenses	$120-$160 copay	Up to $75

[1] Lenses are paid in full, excluding cosmetic extras. Cosmetic extras include (but are not limited to) oversize lenses (61 mm or larger), coated lenses, tinted or photochromic lenses, progressive or blended lenses.

[2] A 20% discount is provided on the out-of-pocket costs for frames that exceed the $150 allowance from a VSP network doctor. A $170 allowance is available for featured brands.

[3] Medically necessary contact lenses may be prescribed by a provider for certain conditions. The provider must receive prior approval from VSP for such contact lenses.

In addition, VSP providers agree to:

- *Glasses and Sunglasses*
  30% off additional glasses and sunglasses, including lens options, from the same VSP provider on the same day of your well vision exam, or get 20% off from any VSP provider within 12 months of your last well vision exam.

- *Retinal Screening*
  No more than a $39 copay on routine retinal screening as an enhancement to your well vision exam.

- *Laser Vision Correction*
  Average 15% off the regular price, or 5% off the promotion price; discounts only available from contracted facilities. After surgery your frames allowance is available once every 24 months from your last date of service.

Low Vision Coverage

Low vision benefits are available (with prior VSP approval) for severe visual problems that are not correctable with regular lenses. Please discuss your options with your provider. Coverage includes:

- Supplemental care – 75% (25% copay)
- Supplemental testing – 100%
- Benefit maximum – $1,000 per two years for services related to low vision

Low vision care from a non-VSP provider is subject to the same limits and copays as described above for a VSP provider. You pay the non-VSP provider's full fee, then are reimbursed up to what would have been paid to a VSP provider.

OBTAINING VISION CARE

To receive eye care services or eyewear from a VSP provider:

- Contact VSP by calling (800) 877-7195 or visiting ***www.vsp.com***.to determine if your provider is in the VSP network or to locate a VSP provider close to your home or work.

- When making an appointment, identify yourself as a VSP member, provide the VSP provider with the employee's Social Security number and first and last name; before your visit they will verify your eligibility and available benefits.

- The patient will be responsible for the cost of any cosmetic options, as well as any frame or contact lens overage.

There's no need to file a claim – the VSP provider does it for you.

To receive service from a non-VSP provider:

- Make an appointment with any provider

- Pay the bill in full

- File a claim for reimbursement. Write the employee's name, date of birth and last four digits of their Social Security number as well as the patient's name, date of birth and relationship to the employee and Northern California Soft Drink Industry and Teamsters Health and Welfare Plan on it, then send the claim along with a copy of the bill to:

  VSP
  Out-of-Network Provider Claims
  P.O. Box 385018
  Birmingham, AL 35238-5018
  (900) 877-7195

All claims must be filed within one year of the date vision services are completed. Reimbursement is made directly to you and can be assignable to the provider if they are willing.

VISION LIMITATIONS AND EXCLUSIONS

Because this Plan is designed to cover your visual needs rather than cosmetic eyewear, there is an extra charge for:

- Blended lenses
- Coated or laminated lenses
- Contact lenses (except as noted above)
- Cosmetic lenses and optional processes
- Frames that cost more than the Plan allowance
- Oversize lenses (61 mm or larger)
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses

The Plan does not cover:

1. Claims received after the 12-month filing limit.
2. Experimental procedures or lenses.
3. Eye exam or corrective eyewear required by an employer as a condition of employment.
4. Medical or surgical treatment of the eyes.
5. Orthoptics or vision training or any associated supplemental testing.
6. Plano lenses.
7. Replacement of lost or broken lenses or frames furnished under these vision benefits (except at the normal intervals).
8. Two pair of glasses in place of bifocals.

DEATH BENEFITS

EMPLOYEE DEATH BENEFIT

If you, as the Employee, die while you are covered under the Plan, your designated beneficiary will be entitled to a death benefit of $5,000.

If you have not designated a beneficiary upon your death or if your designated beneficiary dies before you do, your next of kin will be entitled to the entire death benefit. Your next of kin is determined by the following order:

- Your lawful spouse at the time of your death
- Children (including legally adopted children)
- Parents
- Brothers and Sisters
- Executor or Administrator

If two or more persons are entitled to a death benefit, the benefit will be divided in equal parts between or among them.

If you divorce and your ex-spouse is listed as your beneficiary, that designation will be automatically revoked as of the effective date of your divorce, and your designated beneficiary will be determined under the next-of-kin rules described above, unless you submit a new beneficiary designation.

You may change your beneficiary at any time by filing the required form with the Fund Office.

DEATH BENEFITS IF YOU BECOME PERMANENTLY AND TOTALLY DISABLED

If you become permanently and Totally Disabled while covered under the Plan and before you reach the age of 60, your death benefit will be continued provided satisfactory evidence of such disability is made available to the Board of Trustees.

Your beneficiary will be entitled to the full amount of your death benefit provided:

- your disability continues until the date of your death; and
- written proof of the disability, satisfactory to the Board of Trustees, is supplied to the Fund Office within twelve (12) months of the onset of your disability; and
- the Fund Office receives notice of your death within one (1) year after the date of your death.

DEPENDENT DEATH BENEFIT

If your enrolled Dependent dies while covered under the Plan, you will be entitled to a death benefit as follows:

Spouse	$1,500
Dependent Children:	
Children up to six (6) months	$100
Children older than six (6) months	$500

TIME TO FILE A CLAIM FOR A DEATH BENEFIT

Any claim for an employee death benefit, a disability death benefit, or a dependent death benefit must be received no more than one (1) year from the date of death. Claims for death benefits should be sent to:

Health Services & Benefit Administrators Inc.
4160 Dublin Blvd, Suite 400
Dublin, CA 94568
Attn: NCSD

See page 69 for more information on filing claims and appeals, see the Section Claims and Appeals Procedure starting on page 68.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFITS

This benefit is for Employees only; Dependents are not eligible for Accidental Death & Dismemberment Benefits.

If you suffer one of the following losses as a result of an accidental injury while you are an Employee eligible for benefits under this Plan (provided the loss occurs within 90 days of the date of your accidental injury), the following benefits will be paid to you or your beneficiary:

Accidental Death	$3,000
Loss of:	
• Both Hands, Both Feet, Both Eyes	$3,000
• Any Two of the Above	$3,000
• One Hand, One Foot or One Eye	$1,500

If you suffer more than one loss in an accident, the Plan will only pay benefits for the loss that provides the greater benefits.

Limitations

This benefit is not payable for death or dismemberment resulting from:

1. self-inflicted injury or suicide;
2. bacterial infection;
3. bodily or mental infirmity;
4. disease of any kind from any cause, or as a result of medical or surgical treatment;
5. commission, or attempted commission of, a felony; or
6. war, insurrection or other civil disturbance.

COORDINATION OF BENEFITS

If you and your Dependents are covered under this Plan and another plan (*for example,* your spouse's employer-provided health insurance), you may be entitled to benefits under both plans. When you are covered under two plans, this Plan will coordinate its provision of benefits with the other plan. Other plans may include:

1. any group coverage arranged through any employer, trust, union or employee benefit association;
2. any government, public or tax supported benefit program, or
3. Medicare (Parts A and B) and Medicaid (Medi-Cal).

In the coordination of benefit payments with another plan, this Plan will pay up to, but no more than, 100% of the total charges you incur. Notwithstanding this coordination of benefits rule, the Plan will not pay benefits in excess of what is otherwise provided for under the Plan.

In the coordination of benefit payments, the various plans must determine which Plan is the primary payer, which is the secondary payer and, if applicable, which is the tertiary payer. The primary payer pays benefits first, up to the maximum benefits allowed under its terms without regard to other plans involved. The secondary payer then pays the difference between the amount paid by the primary payer and the total charges you or your Dependents have incurred. The secondary payer will not pay benefits that would exceed benefits provided under its terms (e.g., the amount it would pay if it was the primary payer).

If your spouse or covered Dependent is eligible for other group medical, dental or vision coverage but elected not to participate and the other plan requires a copayment of less than $65 per month, the Fund will pay benefits as though your spouse or Dependent had enrolled in the other group coverage. See "Special Rule for Spouses and Dependents Eligible for Other Coverage" below for more information.

COORDINATION WITH HMOS

If your spouse or covered Dependent is covered by this Plan and a prepaid medical plan (HMO), this Plan will only pay benefits for the out-of-pocket expense (e.g., co-payments and deductibles) incurred when HMO providers are used in accordance with the HMO rules. In other words, if the other plan is an HMO, your spouse / Dependent must obtain care in accordance with the HMO's rules, and this Plan will only pay out-of-pocket expenses that your spouse or Dependent incurred or would have incurred had he / she followed the HMO's rules.

ORDER OF PAYMENT

In order to determine which plan will be primary and which will be secondary, the following rules will apply in the following order:

A plan without a coordination of benefits provision or a plan that bars or substantially restricts coordination with this Plan will be primary. If (1) this Plan is secondary and (2) the plan that would be primary under this provision limits or reduces its payment of benefits because of coordination with this Plan, this Plan will pay no more than it would have paid as a secondary payer had the primary plan paid benefits notwithstanding coordination with this Plan and without regard to such limitation or reduction of benefits because of coordination with this Plan.

Employees and Dependents

1. The plan that covers you as an Employee is primary and pays benefits first before a plan that covers you as a Dependent.

2. The plan that covers your spouse as an Employee is primary before a plan that covers your spouse as a Dependent.

Active / Retired or Laid-Off Employee

The plan that covers the person who is neither retired nor laid-off (or is that person's Dependent) pays benefits first. The plan that covers that person as a retired or laid-off Employee pays benefits second.

COBRA Beneficiaries

The plan that covers the person as an Employee or Dependent of an Employee will be primary and pay benefits before the plan that covers the person as a COBRA beneficiary.

Dependent Children of Parents NOT Separated or Divorced

1. For a child covered under both parents' plans, the primary plan is determined by the "birthday rule." The plan covering the parent whose birthday falls earlier in the calendar year, regardless of birth year, is the primary plan. The plan of the parent whose birthday occurs later in the year is the secondary plan.

2. If another plan does not have the "birthday rule," it will pay its benefits first.

3. If both you and your spouse share the same birthday, then the primary plan will be the one that has covered one parent the longest. The plan covering the parent for the shorter period of time pays benefits second.

Dependent Children of Parents Separated or Divorced

If a child's parents are separated or divorced, the birthday rule does not apply. The following order will apply:

1. The plan of the parent who has custody pays first.

2. The plan of the spouse of the parent with custody (the stepparent), pays next.

3. The plan of the parent without custody pays next.

However, if a "Qualified Medical Child Support Order" (QMCSO) places the financial responsibility for the child's health care expenses on one of the parents then the plan covering that parent will be primary.

Longer / Shorter Length of Coverage

If none of the above rules determines the order of benefits, the plan covering a person longer pays first.

Medicare

This Plan will be primary to Medicare (Parts A and B) under the following circumstances:

1. an active Employee age 65 or older;

2. an active Employee's dependent spouse age 65 or older;

3. the first 30 months of treatment for End Stage Renal Disease (ESRD) received by any covered person. The 30-month period begins on the date dialysis begins. At the end of the 30-month coordination period, Medicare, Parts A and B become your primary coverage and you MUST sign up for Medicare and pay the premium for Medicare Part B. If you do not become entitled to Medicare Parts A and B, this plan will coordinate benefits for ESRD as though you are entitled to Medicare Parts A and B.

4. an active Employee's Dependent who is eligible for Medicare due to disability. (However, the Plan is secondary to Medicare for an active Employee who is eligible for Medicare due to disability.)

SPECIAL RULE FOR SPOUSES AND DEPENDENTS ELIGIBLE FOR OTHER COVERAGE

*If your spouse or Dependent is working and eligible for other group coverage through his or her employer***,** but elects not to participate, the following rules apply:

1. The Fund will pay benefits (on behalf of all beneficiaries) as though your spouse / Dependent was enrolled in the other group coverage unless the other group coverage requires an employee copayment of $65 or more per month. For coordination purposes, the Fund will treat the other plan as providing benefits identical to the Fund's PPO Plan.

2. If the other group coverage is a prepaid medical plan (HMO), the Fund will only coordinate benefits for the out-of-pocket expense that would have been incurred if HMO providers were used, in accordance with HMO's rules.

3. If the other group coverage requires an employee copayment of $65 or more per month, this special rule will not apply and your spouse will be entitled to receive coverage under the Fund to the same extent as a spouse who is not eligible for other group health coverage.

The "birthday rule" described above will not apply to your children unless your spouse actually enrolls in the other coverage and can enroll your children in his or her plan at no additional cost.

How Payments are Coordinated:

Because the benefit paid by the secondary plan is reduced by the amount paid by the primary plan, the benefit under the secondary plan cannot be determined until the primary plan pays. You should always submit your claim to the primary plan first. When the primary plan has paid, attach a copy of the Explanation of Benefits (EOB) when you submit your claim to the secondary plan. If you have met the secondary plan's deductible and the benefit paid by the primary plan is less than 100% of the eligible expense, the secondary plan may pay a benefit.

Examples of Coordination Rules

Here are five examples of how the coordination of benefits rules work:

Example 1: Sam is a driver for ABC Soft Drink Company. His wife Jane is covered as a Dependent under the Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund. Jane has the option of obtaining coverage through her own employer at a cost of less than $65 per month but elects not to do so.

If Jane needs medical care, the Fund will pay benefits as though Jane **had enrolled** in her employer's plan and as though her employer's plan had the same benefits as the Fund's

PPO Plan. Therefore, coverage for Jane's claims by the Fund will be only a small portion of the billed charges and her out-of-pocket costs will be substantial.

If your spouse is eligible for other group coverage through his / her employer at a cost of less than $65 per month, it is to your advantage to make sure he / she is enrolled in the other coverage.

Example 2: Niumi is also a driver for ABC Soft Drink Company. Her husband Khalil is covered *as a Dependent* by Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund PPO Plan, but he is also covered under his own employer's HMO. The HMO has a $10 office visit co-payment with no other out-of-pocket charges if HMO providers are used and the HMO's rules are followed.

The Fund will pay 70% of Khalil's $10 office visit charge (90% if the Doctor is also in the Fund's PPO network). If Khalil uses HMO providers and follows the HMO's rules, he will only pay $3 out-of-pocket (30% of the $10 co-pay). Even if Khalil uses non-HMO Doctors or fails to follow the HMO's rules, the Fund will still pay just $9 – or $7 if non-PPO provider – towards Khalil's medical bills.

If your spouse belongs to an HMO through his / her employer, your out-of-pocket costs could be substantially higher unless he / she obtains care from the HMO providers and follows the HMO's rules.

Example 3: Jon is a driver for the Best Soft Drink Company. His wife Frida and their children are covered *as Dependents* by Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund. Frida also has access to group health insurance through her own employer at a cost of $50 per month for herself. She may also enroll her children at an additional cost of $25 per month. Frida's birthday is in January and Jon's is in July. Frida elects not to enroll in her employer's health plan.

When Frida files a claim, the Fund will pay benefits as though she had enrolled in her employer's plan, and as though her employer's plan provided the same benefits as the Fund's PPO Plan (because the out-of-pocket cost to Frida to participate in her employer's plan is less than $65 per month). When coordinating benefits on covered children, the Fund uses the "birthday rule." However, the "birthday rule" does not apply unless Frida actually enrolls in her employer's group coverage. Under this example, claims for Jon and Frida's children will be paid by the Fund as if there is no other coverage because Frida has not enrolled in other coverage.

Example 4: The same facts as *Example 3* except that Frida enrolls in her employer's coverage for herself but elects not to pay the additional cost to cover her children.

Frida's primary coverage will be her employer's group coverage. The Fund will pay secondary to the other plan. However, Jon and Frida's children will receive primary coverage from the Fund because the other plan requires an additional cost to cover dependents and the "birthday rule" will not apply.

Example 5: The same facts as *Example 3* except that Frida enrolls in her employer's coverage for herself but elects not to enroll her children even though she may do so at no additional cost.

Frida's primary coverage will be her employer's group coverage. The Fund will pay secondary to the other plan. Under this example, the "birthday rule" would apply because Frida can enroll the children in her employer's group coverage at no additional cost. Whichever parent has a birthday earliest in the calendar year has the primary coverage for the children. In this example, Frida' birthday is in January while Jon's birthday is not until July. According to the birthday rule, Frida's coverage will be primary for their children. To avoid potentially large out-of-pocket expenses, Frida should enroll the children in her employer's plan. If she fails to do so, this Fund will coordinate benefits on the children as if they had been enrolled in her employer's plan and benefits will be coordinated as if the other group plan was identical to this Fund's Indemnity Plan.

If the coverage through Frida's employer is an HMO plan, Frida and Jon's children must use the HMO for maximum benefits. If the children do not use the HMO, the Fund will still coordinate benefits *only* on the out-of-pocket expense that would have been incurred had the HMO been used.

If your spouse has a birthday earlier in the year and can enroll his / her children in his / her employer's plan for a copayment of $65 or less per month, you could save a substantial amount of money by making sure your spouse and children are enrolled in and use your spouse's plan under his / her employer.

For questions regarding the application of these rules to any particular claim, call the Fund Office at (855) 690-7250.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of enforcing or determining the applicability of the terms of this provision of the Plan or any similar provision of any other plan, the Trustees may, without the consent of any person, release to or obtain from, any insurance company, organization or person information sufficient to apply the terms of this provision or other similar provisions.

FACILITY OF PAYMENT

Under the terms of the above coordination of benefits rules, the Trustees may reimburse another plan for any amounts due if that other plan pays benefits that this Plan is obligated to pay. The Trustees have the sole authority and discretion to determine when such a payment is warranted under the Plan's coordination of benefits rules. Any amounts paid to another plan under this provision will be designated as benefits paid under this Plan.

RIGHT OF RECOVERY AGAINST THIRD PARTIES

The Plan is entitled to the right of first reimbursement from any recovery of proceeds for damages from any source up to the amount of payments made by the Plan on account of medical, dental, vision care or any other expenses related to or arising out of any injury, illness, disease or other physical or psychiatric condition and / or resulting death for which a third party is or may be legally responsible.

You are obligated to reimburse the Plan for any claims paid relating to such an illness or injury to the extent you recover any amount from a third party. If you fail to reimburse the Plan, the Plan will deduct the amount paid from any of your future benefit claims to offset the amount owed.

The Plan will pay claims for expenses incurred because of an illness or injury for which a third party is (or may be) responsible. By submitting the claim for payment by the Plan, you and / or your covered Dependents are deemed to have agreed to each of the following conditions:

1. that the Plan has established an equitable lien on any recovery received by you (or your Dependent, legal representative, trustee or agent);

2. to notify any third party responsible for your illness or injury of the Fund's right to reimbursement for any claims related to your illness or injury;

3. to hold any reimbursement or recovery received by you (or your Dependent, legal representative, trustee or agent) in trust on behalf of the Plan to satisfy the Plan's equitable lien and cover all benefits paid by the Plan with respect to such illness or injury and to reimburse the Plan from such proceeds promptly for all benefits paid, even if you are not fully compensated ("made whole") for your loss;

4. that the Plan's equitable lien shall take precedence over any other liens, claims, encumbrances, etc., (whether or not the participant or Dependent is made whole) and that the Plan's lien is of first priority over all other claims and rights to your third-party recovery;

5. to reimburse the Plan in full up to the total amount of all benefits paid by the Plan in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Plan as reimbursement up to the full amount of the benefits paid;

6. that the Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise;

7. that, in the event you elect not to pursue your claim(s) against a third party, the Plan shall be equitably subrogated to your right of recovery and may pursue your claims;

8. to assign, upon the Plan's request, any right or cause of action to the Plan;

9. not to take or omit to take any action to prejudice the Plan's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Plan in obtaining reimbursement;

10. to cooperate in doing what is necessary to help the Plan recover the benefits paid or in pursuing any recovery;

11. to forward any recovery to the Fund within ten (10) days of disbursement by the third party or to notify the Fund as to why you are unable to do so; and

12. to permit the entry of judgment against you and, if applicable, your Dependent, legal representative, trustee or agent in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Plan's attorney's fees and costs.

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

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

1. Offset what is paid on your and / or your Dependents' future benefits claims until the Fund is completely reimbursed for the cost of claims submitted as a result of injury or illness caused by the third party, including but not limited to costs incurred in collection; and

2. File a lawsuit against you or your Dependents to fully recover the amount the Plan should have been reimbursed; and/or

3. Take any other action deemed appropriate by the Board of Trustees.

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

If you have questions about how to meet these third party liability rules, contact the Fund Office.

WORKERS' COMPENSATION CLAIMS

Under the terms of the Plan, benefits are not payable for any loss caused by or resulting from any employment, occupation or work for wage or profit. If you incur such a loss, you should file a workers' compensation claim with your Employer.

In the event a workers' compensation claim is denied by your Employer, you may appeal the denial through your Employer's workers' compensation insurance carrier. The Appeals Board will then issue an application for adjudication.

In order for the claim to be considered for payment under the Plan, you must submit a copy of the denial letter and the application for adjudication to the Fund Administrator. A notice and request for allowance of lien will then be sent to you for your signature. The lien form establishes a lien over any payments, including workers' compensation benefits, that you receive for the treatment of your injury, up to the amount of any charges which have been submitted to the Fund Administrator for medical services rendered as a result of the alleged workers' compensation injury of illness. Upon receipt of the executed request for allowance of lien, payment will be made on the pending claims and the Fund Administrator will file the lien claim with the workers' compensation Appeals Board.

DEFINITIONS

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

Contract Rate: The fee the PPO Provider has contractually agreed to accept as payment in full for a service or supply covered under the Plan.

Contributing Employer: Any partnership, corporation or firm which is a party to a Collective Bargaining Agreement, has been approved for participation in the Trust Fund by the Trustees and which makes payments to the Plan on behalf of its Employees and their Dependents for coverage under the Plan.

Contribution: The payment an Employer is required to make on behalf of its Employees in accordance with the provisions of the Trust Agreement and its applicable Collective Bargaining Agreement with a Union.

Covered or Allowable Expense: An expense that is:

- Medically Necessary and not Experimental;
- prescribed by a licensed provider;
- for the care and treatment of a non-occupational accidental bodily injury or sickness;
- incurred while eligible for benefits; and
- not excluded by the Plan.

In no event shall a Covered or Allowable Expense exceed the lesser of the Usual, Customary, Reasonable charges billed by a provider or the Contract Rate for such expense under a Preferred Provider Contract between a provider and this Plan or between a provider and the plan with which this Plan is coordinating benefits. In the event of incurring a claim from a non-Preferred Provider, you are responsible for any billed charges in excess of what this plan pays.

Custodial Care: Care provided primarily for maintenance or to assist a covered person in the activities of daily living. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating preparation of special diets and supervision of medication that does not require the constant attention of trained medical personnel.

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

Doctor or Physician: A Doctor licensed as a Medical Doctor (M.D.) or Osteopath (D.O.). To the extent they are practicing within the scope of their license, Doctor shall also include a Dentist, Podiatrist, Chiropractor, Optometrist, Psychologist, Physical Therapist, Registered Nurse, Nurse-Midwife, or Psychiatrist.

Before you receive treatment from any practitioner other than an M.D. or D.O., check with the Fund Office to find out if the expenses will be recognized as a Covered Expense.

Emergency: Emergency means a sudden and unexpected onset of a medical condition which in the absence of medical attention could reasonably place the individual's health in jeopardy, cause serious medical consequences, serious impairment to bodily functions or serious and permanent dysfunctions of any bodily organ or part.

Employee: An individual employed by a Contributing Employer on whose behalf Contributions are made to this Plan.

Experimental: Any procedure, service, supply, other items or combination of the foregoing:

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

The Fund will determine whether a treatment, service or supply is Experimental. In making such a determination, the Fund may review established utilization review procedures, refer to the current applicable literature, federal and state laws and regulations and consider any other information the Fund deems is relevant or appropriate. Such determination will be conclusive and binding with respect to all concerned parties.

Fund Office / Fund Administrator: The Company appointed by the Trustees to perform the day-to-day administration of the Trust Fund and its benefit Plans. The Fund Administrator is Health Services & Benefit Administrators (HS&BA), located at 4160 Dublin Blvd., Suite 400, Dublin, CA 94568. The telephone number is (855) 690-7250.

Health Maintenance Organization / HMO: A managed care organization that provides a form of prepaid health insurance coverage fulfilled through its own facilities and staff or through contracted hospitals, Doctors, and other providers. You must generally obtain services from within the HMO's network. The Fund's HMOs are Kaiser Permanente (referred to as the Kaiser HMO Plan)(medical coverage) and UnitedHealthcare Dental.

Hospital: An institution which:

- has permanent full-time facilities for bed care for five or more resident patients;
- has a Doctor in regular attendance;
- provides constant 24 hour-a-day service by a Graduate Registered Nurse;
- primarily provides diagnostic and therapeutic facilities for the medical and surgical care of patients;
- is operating lawfully in the jurisdiction where it is located; and
- is not a rest home, nursing home, convalescent home, a place for the aged or solely provides treatment for chemical dependency (other than a facility approved by the Trustees).

Medical Review Organization: An organization that enters into a contract with the Fund with the objective of reviewing the appropriateness and quality of care and to provide the Fund with cost containment services, including pre-admission screening, second opinion referrals, medical case management and retrospective review programs.

Medically Necessary or Medical Necessity: Services or supplies which are determined by the Plan to be:

- appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition;
- within the standards of good medical practice within the organized medical community;
- not primarily for the convenience of the participant, your Physician or another provider; and
- the most appropriate supply or level of service which can be safely provided. For Hospital stays, this means that acute inpatient care is necessary to the kind of services you require, and that safe and adequate care cannot be provided on an outpatient basis.

Plan or Fund or Program: The Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund.

PPO Provider: A Hospital, Doctor, or other provider who participates in the Anthem Blue Cross Prudent Buyer network (large group).

Qualified Medical Child Support Order (QMCSO): A medical support order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law under that state, which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Plan participant is eligible and which is determined by the Plan to be qualified under the terms of ERISA pursuant to 29 U.S.C., Section 1169 and applicable state law.

Totally Disabled or Total Disability: You are Totally Disabled when prevented, by reasons of physical or mental injury or illness, from engaging in any occupation for wages or profit. Your Dependent is Totally Disabled when he / she is prevented by reason of physical or mental injury or illness from engaging in the normal activities of a person of similar age and sex.

Union: A labor organization affiliated with the International Brotherhood of Teamsters, or representing the employees of such an affiliate, signatory to a Collective Bargaining Agreement with a Covered Employer calling for participation in the Plan.

Usual, Customary and Reasonable (UCR): A charge is Reasonable and Customary if the Fund determined that the amount charged by a provider of services or supplies does not exceed the fair value of the service or supply. A charge is Usual if the Fund determines that it is the amount the provider ordinarily charges for a given procedure or service. When determining whether a charge is Reasonable and Customary, the Fund applies the following criteria:

- "Customary" means the charge is within the range of prevailing fees charged by providers of similar training or experience, within the same geographic area, for the performance of a specific service or procedure, and

- "Reasonable" means the fees are customary and justified considering medical complications or special circumstances requiring additional time, skill or experience in connection with the performed service or procedure.

CLAIMS AND APPEALS PROCEDURE

This section describes how you claim benefits under the Plan. Different procedures apply to Urgent, Concurrent Care, Pre-Service, Post-Service and Disability Claims. In some circumstances, the Plan will deny your Claim for benefits, in whole or in part. There are many reasons why the Plan may deny all or part of your Claim. ***For example,*** you may have received services or a supply not covered by the Plan, the individual treated is not covered by the Plan or the service provider has charged more than the UCR amount paid by the Plan. If any part of your Claim is denied, you may appeal the decision to the Board of Trustees. This section describes the Claims process and applicable time limits within which you must file an appeal.

DEFINITIONS

1. **Adverse Decision or Adverse Decision on Appeal:** A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part), for a benefit.

2. **Claim:** Any request for Plan benefits made in accordance with the Plan's claims filing procedures.

3. **Claim Concerning Eligibility:** A Pre-service or Post-Service Claim that concerns whether you or your Dependent is eligible for benefits.

4. **Concurrent Care Claim:** A Claim that involves the reduction or termination of a treatment (other than by Plan amendment or termination) before the end of a previously approved course of treatment. A Concurrent Care Claim also refers a Claim to extend a pre-approved course of treatment.

5. **Disability Claim:** A Claim that requires a finding of Total Disability as a condition of benefits.

6. **Pre-Service Claim:** A Claim that will not be covered by the Plan unless you have asked for and received the Plan's approval for treatment.

7. **Post-Service Claim:** Any Claim for medical care other than a Pre-Service or Disability Claim.

8. **Urgent Care Claim:** Any Claim for medical care or treatment which, if processed according to the ordinary time limits for Pre-Service Claims:

    a. could seriously jeopardize your life, your health or your ability to regain maximum function, or

    b. in the opinion of the Doctor who has knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment described in your Claim.

HOW TO FILE A CLAIM

Unless otherwise directed below, you should send Claims to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Forms for claims can be found on *anthem.com*. For questions regarding claims and benefits, please call 1-800-845-3604. No payment shall be made on Claims received more than one (1) year from the date of service.

Filing Pre-Service Claims

N**o** benefits are payable unless you have received approval before receiving the following benefits:

1. **Hospital Admissions:** Anthem Blue Cross, the Fund's Utilization Review Organization, must approve any Hospital admission (except Emergency admissions) before you go to the Hospital.

2. **Treatment for Alcohol or Chemical Dependency:** The Teamsters Assistance Plan of Northern California (TAP) must pre-authorize any Claim. TAP can be reached at (510) 562-3600. (See page 37 for more details.)

3. **Home Care or Alternative Treatment of any kind.**

4. **Hospice Care.**

5. **Organ Transplants.**

6. **Orthodontic Services.**

For pre-authorization for Hospital admissions, home or alternative care, hospice care or organ transplants, you (or your Doctor) must call Anthem Blue Cross at (800) 274-7767. For pre-authorization for orthodontic services, you must call UnitedHealthcare Dental Plan at (800) 999-3367 if you are covered by the UnitedHealthcare Dental Plan or Anthem Dental PPO Plan at (844) 729-1565 if you are covered by the Anthem Dental PPO Plan.

Anthem Blue Cross, TAP or the Fund Administrator will respond to **Pre-Service Claims** within the following timelines:

1. **Urgent Care Claims:** As soon as possible but not later than *72 hours* after receiving your request for authorization**.** If you do not supply sufficient information to determine whether the benefits are covered, Blue Cross will notify you or your Doctor as soon as possible but not later than *24 hours* after receipt of the Claim. Blue Cross will inform you or your Doctor of the additional information needed to complete review of the Claim. You (or your Doctor) must respond within *48 hours* of receiving notification of the required information.

2. **Non-Urgent Pre-Service Claims:** Within *fifteen (15) days* except that in cases where more time is required, Blue Cross of California, TAP or the Fund Administrator will have fifteen (15) additional days to respond, in which case you will be notified why the Fund requires additional time and when the Fund will provide a response. If your Claim is not an Urgent Care Claim and the Fund needs more time to process your Claim because it needs more information from you or your Doctor, you and your Doctor have up to *forty-five* (*45) days* to provide the additional necessary information. If you do not provide the necessary information on time, your Claim will be denied. After the Fund receives the information needed from you or your Doctor, the Fund will respond to your Claim within *fifteen (15) days.*

Filing Post-Service Claims
If you submit a completed Post-Service Claim and the Fund requires no additional information to reach a decision, the Fund will decide your Claim and notify you of the decision within *thirty (30) days* of its receipt. If the Fund requires additional time to reach a decision, the Fund may extend the 30-day deadline by an additional *fifteen (15) days*. You will be notified before the end of the initial thirty (30) days as to why the Fund needs additional time and when you can expect to receive a decision on your Claim.
If you did not submit sufficient information for the Fund to decide your Claim, you will be informed of the required additional information and you will have *forty-five (45) days* from date you receive the Fund's notice to supply the additional information. The time for the Fund to make a decision regarding your Claim is tolled from the time the Fund notifies you that it needs more information until the time you provide the information. If you do not provide the additional information within the *forty-five (45) day period*, the Fund will deny your Claim.

Filing Disability Claims
If you file a complete Disability Claim (e.g., for continuation of benefits on the basis that you have become permanently and Totally Disabled), the Fund will decide your Claim and notify you of its decision within *forty-five (45) days* of its receipt by the Fund. The Fund can extend that deadline twice by an additional *thirty (30) days* if more time is needed to decide your Claim. In such case, you will be notified before the end of the initial 45-day period (or before the end of the 30-day extension period if the Fund has already extended the deadline) of both the reason why the Fund requires additional time and when you can expect to receive a decision on your Claim.

If you did not submit sufficient information for the Fund to decide your Claim, you will be informed of the required additional information and provided *forty-five (45) days* from the date you receive the Fund's notice to supply the addition information. The time for the Fund to make a decision regarding your Claim is tolled from the time the Fund notifies you that it needs more information until the time you provide the information. If you do not provide the additional information within *forty-five (45) days*, the Fund will deny your Claim.

Filing Concurrent Care Claims
For Concurrent Care Claims involving the reduction or termination of the course of treatment before the end of the time or number of treatments initially approved, you will be notified of the reduction or termination in advance of the reduction or termination, and you will be allowed to appeal and obtain a determination on appeal before the benefit is reduced or terminated. For a Concurrent Care Claim requesting that a course of treatment be extended beyond the period of time or number of treatments initially approved and the request involves urgent care, 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. For a Concurrent Care Claim requesting that a course of treatment be extended beyond the period of time or number of treatments initially approved that does not involve urgent care, you will be notified as if the Claim was a Pre or Post-Service Claim, whichever applies.

Notice of Adverse Decision
A notice of an Adverse Decision will be provided in writing in a culturally and linguistically appropriate manner and will include the following:

a. the specific reason(s) for the adverse decision;

b. reference to the specific Plan provisions(s) on which the adverse decision is based;

c. a description of any additional material or information needed from you in order to make a full and complete Claim and the reason why it is needed;

d. an explanation of the Plan's appeal procedures and time limits and a statement about your rights to bring a civil action under ERISA following an Adverse Decision on Appeal of the denial of your Claim;

e. a copy of any internal rule, guideline or protocol that the Fund relied upon to decide your Claim or a statement that a copy is available upon request at no charge. For Disability Claims, you will receive a copy of this information or a statement that this information does not exist;

f. for adverse decisions based on the absence of Medical Necessity or the use of Experimental or investigational treatment (or any similar reason), an explanation of the scientific or clinical judgment relied upon for the determination of your Claim (or a statement that this explanation is available upon request);

g. information sufficient to identify the Claim involved and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

h. the denial code and corresponding meaning and description of the Plan's standard, if any, used to deny the Claim;

i. for Disability Claims, a statement that you may receive, upon request and free of charge, reasonable access to and copies of any documents in the Fund's possession that are relevant to your Claim along with a discussion of the decision, including an explanation of the basis for disagreeing with any Social Security Administration disability determination or the views of any health care or vocational professionals presented by you or obtained by the Plan.

HOW TO APPEAL A DENIAL OF YOUR CLAIM

If you disagree with the decision on your initial Claim, you (or your authorized representative) may file a written appeal to the Board of Trustees within *one hundred eighty (180) days* after your receipt of the notice of adverse decision. You may, however, appeal an adverse decision regarding **Urgent Care Claims** by calling the Anthem at (800) 274-7767 or by presenting a written appeal. You should include the reasons you believe the Claim was improperly denied and all additional facts and documents you consider relevant in support of your appeal. If you don't appeal on time, you may lose your right to file suit in a state or federal court because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court).

The members of the Fund's Board of Trustees will decide your appeal. They will not defer to the initial adverse benefit determination and will consider all comments, documents and records or other information you submit, even if they were not submitted or considered during the initial Claim decision. Their decision on your appeal will be made on the basis of the record, including any additional documents and comments you submit.

If your Claim was denied on the basis of a medical judgment (such as the absence of Medical Necessity or the use of an Experimental or investigational treatment), the Board will consult a health care professional with training and experience applicable to the relevant field of medicine. Upon request, you can obtain the name of any professional consultant and the advice (if any) that was provided concerning your Claim (even if the Board did not rely on this advice in making its decision). Before the Plan sends an Adverse Decision on Appeal, you will be given, free of charge and sufficiently in advance of the date the Adverse Decision on Appeal is required to be provided, information regarding any new or additional evidence or rationale used to decide your Claim. You must respond to this information within *forty-five (45) days*.

You will receive notice of the decision on your appeal within *seventy-two (72) hours* for **Urgent Care Claims** and with *thirty (30) days* for other **Pre-Service Claims.** Appeals of **Post-Service Claims** and **Disability Claims** will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal. If, however, your request for review is received within thirty (30) days of the *next* regularly scheduled Board meeting, your appeal will be decided at the *second* regularly scheduled Board meeting following receipt of your appeal. In special circumstances, review of your appeal may be delayed until the *third* regularly scheduled Board meeting following receipt of your appeal. You will be notified in writing if an extension is necessary. You will be notified of the decision on your appeal as soon as possible but no later than five (5) days after the Board of Trustees reaches a decision on your appeal.

A notice of an Adverse Decision on Appeal will be provided in writing in a culturally and linguistically appropriate manner and will include the following:

a. the specific reason(s) for the adverse decision;

b. reference to the specific Plan provisions(s) on which the adverse decision is based;

c. a statement that you may receive, upon request and free of charge, reasonable access to and copies of any documents in the Fund's possession that are relevant to your Claim;

d. a statement about your rights to bring a civil action under ERISA;

e. a copy of any internal rule, guideline or protocol that the Fund relied upon to decide your Claim or a statement that a copy is available upon request at no charge. For Disability Claims, you will receive a copy of this information or a statement that this information does not exist;

f. for adverse decisions based on the absence of Medical Necessity or the use of Experimental or investigational treatment (or any similar reason), an explanation of the scientific or clinical judgment relied upon for the determination of your Claim (or a statement that this explanation is available upon request);

g. information sufficient to identify the Claim involved, and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

h. the denial code and corresponding meaning and description of the Plan's standard, if any, used to deny the Claim;

i. a discussion of the decision. For Disability Claims, the discussion of the decision will include an explanation of the basis for disagreeing with any Social Security Administration disability determination or the views of any health care or vocational professionals presented by you or obtained by the Plan;

j. For Disability Claims, a description of any contractual limitations period that applies to your right to bring an action under ERISA and the calendar date on which the limitations period expires.

Right to Sue
A lawsuit to obtain benefits filed before you have appealed the denial of your Claim will be deemed untimely if it is filed:

1. before the time period for filing an appeal has ended;
2. before you have appealed the denial of your Claim; or
3. while your appeal is still pending.

Also, any lawsuit must be filed within one year after your appeal is denied.

Claims and Appeals Timetable
The timeline described above for filing and appealing Claims is summarized in the chart below.

TIME LIMITS	TYPE OF CLAIM			
	Urgent Care Claim	**Pre-Service Claim *(Non-Urgent)***	**Post-Service Claim**	**Disability Claim**
To make an initial Claim determination (see above for different rules for Concurrent Care Claims)	72 hours (depending on medical circumstances)	15 days (depending on medical circumstances)	30 days	45 days
Extension (if proper notice and delay is beyond the Plan's control)	None	15 days	15 days	30 days (two 30 day extensions possible)
To request missing information from claimant	24 hours	15 days	30 days	45 days
For claimant to provide missing information	48 hours	45 days	45 days	45 days
For claimant to request appeal	180 days	180 days	180 days	180 days
To make determination on appeal	72 hours (depending on medical circumstances)	30 days	1st, 2nd or 3rd Board of Trustees meeting after submission	1st, 2nd or 3rd Board of Trustees meeting after submission

ADDITIONAL CLAIMS PROVISIONS

Benefit Payments
All benefits will be paid to the participant by the Fund as soon as reasonably practicable after receipt of satisfactory written proof to the Plan that covers the occurrence, character and extent of the event for which the Claim is made.

Benefits Not Subject to Alienation
Plan benefits will not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person. However, a participant may direct that his or her benefits may be paid to a Hospital or any provider of medical, dental or Hospital services or supplies in consideration for services rendered or to be rendered, or supplies furnished or to be furnished, or to any other person or agency that may have provided or paid for, or agreed to provide or pay for, any Plan benefits.

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

Payments Made in Error
In the event the Plan erroneously makes benefit payments to a participant in excess of the amounts provided for by this Plan, makes benefit payments to a participant for expenses for which benefits are not payable under this Plan, or makes benefit payments to an individual who fraudulently participates in the Plan based on a misrepresentation of facts, The Plan may require that the erroneous amounts will be repaid to the Fund by the participant or individual. If such amounts are not repaid by the participant or individual, the Plan may deduct the amount erroneously paid from any future benefit payments due the participant or the Trustees may file suit to recover any amounts due.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use and disclose Protected Health Information ("PHI") to the extent permitted and in accordance with the Health Insurance Portability and Accountability Act of 1996, and regulations issued thereunder, including, without limitation, those regulations at 45 C.F.R. Parts 160 through 164 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

Subject to obtaining written certification as required below, the Plan may disclose PHI to the Board (the "Plan Sponsor"), provided the Plan Sponsor does not use or disclose such PHI except:

- To perform administrative functions which the Plan Sponsor performs for the Plan;
- To obtain premium bids from insurance companies, HMOs or other health plans for providing group insurance coverage under the Plan;
- To modify, amend, or terminate the Plan; or
- As permitted by the Plan, or as required by law.

In no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f). The Plan shall not disclose PHI to the Plan Sponsor unless the Plan Sponsor agrees to:

- Not use or further disclose the PHI other than as permitted by the Plan, or as required by law.
- Ensure that any agent who received PHI from the Plan agrees in advance to the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.
- Make available to an Eligible Employee or Dependent his or her PHI in accordance with 45 CFR §164.524.
- Make available for amendment the PHI of an Eligible Employee or Dependent who requests an amendment to his or her PHI and incorporate any amendments to his or her PHI in accordance with 45 CFR §164.526.
- Make available the information required to provide an accounting of disclosures to an Eligible Employee or Dependent who requests an accounting of disclosures of his or her PHI in accordance with 45 CFR §164.528.
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).

- If feasible, return to the Plan or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure that the adequate separation required by 45 CFR §164.504(f)(2)(iii) between the Plan and the Plan Sponsor exists.

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure described above.

Notwithstanding any other provision herein, the Plan may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or

- Modifying, amending, or terminating the Plan.

The Plan may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor.

The Plan Sponsor shall only allow access to PHI to the Privacy Officer, the Administrator, employees on the Administrator's benefits staff and accounting staff with responsibility for supporting and performing administrative functions for the Plan, members of the Board of Trustees (including, alternates, and the Industry Representative, if any), and Business Associates under contract to the Plan. Such persons shall only have access to and use such PHI to the extent necessary to perform the appropriate supporting and administrative functions that the Plan Sponsor performs for the Plan. In the event that any such person does not comply with the provisions of this Section, the Plan Sponsor shall take appropriate action for resolving the non-compliance, including disciplinary action, if appropriate.

The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan,

- Ensure that the adequate separation discussed above specific to electronic PHI is supported by reasonable and appropriate security measures,

- Ensure that any agent to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

For purposes of complying with HIPAA, the Plan is a "Hybrid Entity" (as such term is defined in HIPAA) because it has both health plan and non-health plan functions. The Plan designates that this Section applies to its health care components that are covered by HIPAA Privacy Regulations and no other Plan functions or benefits.

For purposes of this Section, the following terms shall have the meaning described below unless otherwise provided by the Plan:

- "Protected Health Information" means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to a member, and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information includes information of persons living or deceased.

- "Summary Health Information" means information that may be individually identifiable health information, and (i) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and (ii) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

For more information about the Plan's use and disclosure of PHI, please review the HIPAA Notice of Privacy Practices maintained by the Plan. A copy of the Plan's HIPAA Notice of Privacy Practices may be obtained by mailing a request to the Plan's Privacy Officer.

The Plan has designated Mike Taime as the Privacy Officer and contact person for all issues regarding patient privacy and your privacy rights. You may contact him at:

Privacy Officer
Northern California Soft Drink Industry and Teamsters Health & Welfare Trust Fund
4160 Dublin Blvd, #400
Dublin, CA 94568
Telephone: 855-690-7250
Fax: 925-833-7301

GENERAL INFORMATION

THE TRUST FUND

The benefits provided under the Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund are funded under the terms provided for in the applicable Collective Bargaining Agreement between the participating local Unions and Contributing Employers. The amount of such Contributions is determined through the collective bargaining process. The Fund's Board of Trustees anticipates that the Plan will continue as long as the Collective Bargaining Agreement so provides or until the bargaining parties elect to discontinue the Fund or Plan. The Board of Trustees reserves the right, to the extent not explicitly reserved by the bargaining parties, to change or modify the Plan at any time for any reason without the specific approval of any person. Any change or modification of the Plan will not affect a claim incurred by an Employee or covered Dependent before such change or modification is adopted.

THE BOARD OF TRUSTEES

The Board of Trustees is responsible for the operation of the Fund and is made up of four Trustees appointed by the Contributing Employers and four Trustees appointed by the Union. The names and addresses of these Trustees are shown below.

Union Trustees

Dennis Hart
Teamsters Local 853
2100 Merced Street
San Leandro, CA 94577

Jesse Casqueiro
Teamsters Local 853
7750 Pardee Lane
Oakland, CA 94621

Mark Hawkins
Teamsters Local 70
400 Roland Way
Oakland, CA 94621

Brian Indelicato
Teamsters Local 896
301 Georgia Street
Vallejo, CA 94590

Employer Trustees

Jeff Carlsen
Reyes Holdings, LLC
6250 N. River Road, Suite 9000
Rosemont, IL 60018

Keely Khan
Reyes Holdings, LLC
6250 N. River Road, Suite 9000
Rosemont, IL 60018

Chris Lopez
Dr. Pepper Snapple Group
2009 Farallon Drive
San Leandro, CA 94577

Penny Schumacher
Safeway, Northern California Division
5918 Stoneridge Mall
Pleasanton, CA 94588

Robert Graham (Alternate)
Reyes Holdings, LLC
6250 N. River Road, Suite 9000
Rosemont, IL 60018

CONTRIBUTING EMPLOYERS AND PARTICIPATING UNIONS

A list of Contributing Employers may be obtained from the Fund Office. You may receive from the Fund Office on written request, information concerning whether a particular Employer or Union participates in the Fund and, if so, the Employer or Union's address. The Plan is maintained pursuant to Collective Bargaining Agreements. A copy of any such agreement may be obtained by participants or beneficiaries upon written request to the Fund Office and is available for examination by participants or beneficiaries during normal business hours.

AGENT FOR SERVICE OF LEGAL PROCESS

The Plan's agent for service of legal process is:

Matthew Clizbe
Health Services & Benefit Administrators
4160 Dublin Blvd., Suite 400
Dublin, CA 94568

Legal process may also be served on any Trustee.

ADMINISTRATION OF THE TRUST FUND

The Plan is administered by the Board of Trustees which contracts with Health Services & Benefit Administrators for administrative services. You may write to the Board of Trustees at the following address:

Northern California Soft Drink Industry and Teamsters
Health and Welfare Trust Fund
Health Services & Benefit Administrators
4160 Dublin Blvd., Suite 400
Dublin, CA 94568

SOURCE OF BENEFITS

The Plan is self-funded and the financing of Fund benefits is the responsibility of Contributing Employers, pursuant to the terms of Collective Bargaining Agreements entered into with a Participating Local Union.

PPO Medical Plan benefits are paid directly by the Fund. If you have enrolled in the Kaiser HMO Plan, your medical benefits are funded and paid directly by Kaiser Permanente. Prescription drug, dental, vision, death and accidental death and dismemberment benefits are paid directly by the Fund.

The Fund utilizes the services of Anthem Blue Cross to provide a network of contracted medical and dental providers and for utilization and concurrent review services. OptumRx provides a pharmacy network, Teamsters Assistance Program (TAP) provides substance abuse case management services and VSP provides a network for vision care, Kaiser Permanente provides the prepaid medical option and UnitedHealthcare Dental provides a prepaid dental option.

The contact information of the organizations named above are as follows:

Kaiser Permanente
(800) 464-4000

Anthem Blue Cross (Medical Review Organization)
(800) 274-7767

Anthem Dental PPO Plan
(844) 729-1565

OptumRx
(800) 797-9791

Teamsters Assistance Program of Northern California (TAP)
(800) 253-8326

VSP
(800) 877-7195

UnitedHealthcare Dental Direct Compensation
(800) 999-3367

PLAN YEAR
The Plan Year runs from November 1 through October 31.

TRUST FUND RECORDS
The financial and claim experience records of the Fund are kept on a fiscal year basis, ending October 31 of each year.

EMPLOYER IDENTIFICATION NUMBER
The Fund's Employer Identification Number is **94-6330971.**

The Plan Identification Number is **501.**

TYPE OF PLAN
The Plan is a welfare benefit plan, providing health and welfare benefits to eligible Employees and their Dependents.

DISCRETIONARY AUTHORITY OF THE BOARD OF TRUSTEES
The Board of Trustees reserves the right to make any determination of fact necessary or proper to the administration of this Fund. Further, the Board of Trustees shall have sole power and authority to construe and interpret the provisions of the Trust Agreement and this Summary Plan Document, including, but not limited to, any provisions relating to eligibility of Employees, their Dependents and beneficiaries to receive benefits. Such determinations shall be final and binding upon all parties, including Employees, their Dependents and beneficiaries.

DISCLAIMER
The benefits described in this booklet, other than the prepaid (HMO) options, are not insured by any contract of insurance and there is no liability on the Board of Trustees or any individual or entity to provide payment over and above the amounts in the Fund collected and available for such purposes.

ONLY THE FULL BOARD OF TRUSTEES IS AUTHORIZED TO INTERPRET THE PLAN OF BENEFITS DESCRIBED IN THIS BOOKLET, AND NO INDIVIDUAL TRUSTEE, UNION REPRESENTATIVE OR EMPLOYER REPRESENTATIVE IS AUTHORIZED TO INTERPRET THIS PLAN ON BEHALF OF THE BOARD OR TO ACT AS AN AGENT OF THE BOARD. THE TRUSTEES HAVE AUTHORIZED THE FUND OFFICE TO RESPOND IN WRITING TO WRITTEN INQUIRIES FROM PLAN PARTICIPANTS. AS A CONVENIENCE TO PARTICIPANTS, THE FUND OFFICE WILL PROVIDE ORAL ANSWERS REGARDING COVERAGE ON AN INFORMAL BASIS. HOWEVER, NO SUCH ORAL COMMUNICATION IS BINDING UPON THE BOARD OF TRUSTEES.

STATEMENT OF ERISA RIGHTS

The ERISA Statement of Rights, provided below, provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

As a participant in the Northern California Soft Drink Industry and Teamsters Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. You may examine, without charge, at the Fund's Administration Office and at other specified locations such as worksites and union halls, documents governing the Plan, including insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. You may obtain, upon written request to the Board of Trustees or the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Fund Office may make a reasonable charge for the copies.

3. You should 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

You can continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for continued coverage. Review the rules governing your COBRA continuation coverage rights in this Summary Plan Description and the documents governing the Plan.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. These people, called "fiduciaries" of the Plan, have a duty to operate your Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union or other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. However; this rule neither guarantees continued employment, nor affects your Employer's right to terminate your employment for other reasons.

ENFORCE YOUR RIGHTS

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, and you have exhausted the Plan's claims and appeals procedures, you may file suit in state or federal court. In addition, if you disagree

with the Plan's decision or failure to reach a decision concerning the qualified status of a medical child support order, you have requested the Trustees to review your concern and you are dissatisfied with their decision, you may file suit in federal court.

You may seek assistance from the U.S. Department of Labor or you may file suit in a federal court if Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights. 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 your costs and legal fees. If you lose, the court may require you to pay these costs and legal fees; for example, if the court finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Fund Office, 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.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-998-7542.