Southern California Local Union 831 Employer Health Fund

Benefit Highlights...

Physicians Assistants Benefit

Effective June 1, 2006, the Southern California Local 831 - Employer Health Plan will cover Physician Assistants while performing medically necessary services within the scope of their license.

Hearing Aid Benefit

Effective November 1, 2000, Hearing Aids are covered under all 4 levels. Below is the Schedule of Benefits set forth by the Trustees:

Audiologist visit (hearing test)	up to $75.00 per visit
Ear Molds	up to $50.00 per mold
Hearing Aid	up to $800.00 per ear

These benefits are not subject to Plan Deductibles or co-insurance requirements.

The audiologist visit (hearing test) is limited to one per year. Ear molds and hearing aids are limited to one every four years for each ear except that ear molds are allowed up to twice a year, if needed, for each ear for an eligible child up to age 19 (eligible children over age 19 are subject to the four year limit).

If you are a Kaiser member, you must have your hearing examination performed at a Kaiser facility. You may then purchase your hearing aids from any dispenser and submit your bill to the Trust Office for reimbursement.

Contraceptive Devices Benefit

Effective January 1, 2006, the Plan's prescription coverage was extended to include most prescription contraceptive devices.

These include prescription oral, transdermal, injectable, and intravaginal contraceptive medications and contraceptive emergency kits (available only at retail).

Not included are over the counter contraceptives and prescription barrier contraceptives.

Except as noted above, prescriptions may be purchased at the retail pharmacy or through the mail order pharmacy.

Eligibility Requirements

The monthly work hours required to be eligible for Health Plan benefits under all Plan Levels is outlined below for the contribution rate of $7.65.

Schedule of Hours

	Level 1	Level 2	Level 3	Level 4
Hours needed @$7.65	140	120	100	80
Benefit Credits Required	1,071	918	765	612
Maximum "Bank"	5,355	4,590	3,825	3,060

You may accumulate up to a maximum of five (5) months of Benefit Credits/Hours in your Benefit Credit/Hour Bank. As you know, if you work more hours than are necessary to earn the Benefit Credits/Hours required for the level of coverage you have selected, you will accumulate reserve Benefit Credits/Hours in the Benefit Credit/Hour Bank. These Benefit Credits/Hours will be used if you don't otherwise have enough work hours to maintain eligibility, until there are insufficient Credits to use for a month's eligibility.

Indemnity Dental Plan (Plan Levels 1, 2 and 3)

Effective October 1, 2006, the Southern California Local 831 - Employer Health Plan will cover dental implants to replace teeth that were extracted while you were covered by the Plan.

Effective July 1, 2007, the Southern California Local 831 — Employer Health Plan lifetime orthodontia maximum increased to $2,500. For participants who previously met the maximum benefit but are still in treatment, an additional $700 will be payable toward continuing treatment. This benefit is available for eligible children only.

The Plan will cover sealants for first and second molars for eligible children up to age 15. This benefit, however, is limited to once every three years.

Southern California Local Union 831 Employer Health Fund

Benefit Highlights...

Indemnity Plan Prescription Drug Benefit

Effective September 1, 2009, the Trust Fund is pleased to offer Optum Rx. All retail prescriptions must be purchased at Optum Rx Network Pharmacies. Most major pharmacies are on the Plan.

Prescription Drug Mail Order member co-payment is 10% per prescription through Optum Rx. Please note that all maintenance drugs must be supplied through the Mail Order Program.

Prescriptions will be paid as described below.

Plan pays: 80% of Allowable Charges-Retail (if purchased at the pharmacy) -Subject to no deductible

Plan pays: 90% of Allowable Charges-Mail Order - subject to no deductible

Selecting Your Plan Level

To ensure your eligibility for Health coverage, select a Plan Level with the monthly hour requirements that best matches your work hours.

To request an enrollment form or to receive further assistance in selecting a Plan level, contact the Trust Fund Office at 1.877.572.7005.

Health – Buy-Up Option

Effective January 1, 2010, the Health Buy-up Option is available to **those members who qualify** and is **limited to a six (6) month period.**

Buy-up Option qualifications:

If an eligible employee's work hours drop so that he or she would lose eligibility due to insufficient hours or you do not have enough bank hours, then you will be allowed to purchase up to 50% of your required hours to continue your eligibility. You must pay the highest Health & Welfare contribution rate stated in the collective bargaining agreement in effect at the time of your credit hour purchase.

Participant must have at least 50% of the hours required for the Level Option they are under to qualify for the Buy-Up Option.

Level 1	140 hours - must have 70 hours
Level 2	120 hours - must have 60 hours
Level 3	100 hours - must have 50 hours
Level 4	80 hours - must have 40 hours

For Example purposes only:

An employee is covered under Plan Level 3 but his hours dropped to 50, The required number of hours for Plan Level 3 is 100 hours a month. The employee has no bank hours. The difference between the hours worked and hours required is 50 hours. You would multiply 50 hours @ $7.65 = $382.50

Required hours for Level 3 - 100 hours
Hours actually worked 50 hours
Difference 50 hours

50 hours x $7.65 = $382.50 Buy-Up

Questions?

Should you have any questions, please contact Trust Fund Office at 1.877.572.7005.

Sincerely,

BOARD OF TRUSTEES

Statement of Claim For Group Medical Expense Benefits

LOCAL UNION 831 EMPLOYER HEALTH & WELFARE TRUST FUND

MAIL TO: LOCAL UNION 831
P.O. Box 5528
El Monte, CA 91734
(626) 279-3080

HOW TO FILE A CLAIM

1. COMPLETE THIS SIDE OF FORM, ANSWER **ALL** QUESTIONS.
2. COMPLETE THE TOP PORTION OF REVERSE SIDE OF THIS FORM AND SIGN THE AUTHORIZATION TO RELEASE INFORMATION.
3. HAVE ATTENDING PHYSICIAN COMPLETE REVERSE SIDE OF FORM.
4. ATTACH ITEMIZED BILLS – **IMPORTANT** – EACH BILL MUSH SHOW:
   (1.) NAME OF PATIENT, (2.) DATE EACH EXPENSE WAS INCURRED, AND (3.) NATURE OF ILLNESS OR INJURY,
   IF THE BILL DOES NOT SHOW THIS INFORMATION, PLEASE WRITE IT ON THE BILL AND SIGN YOUR NAME.
5. FORWARD COMPLETED FORM AND BILLS TO **THE ADMINISTRATOR** IN THE SELF-ADDRESSED ENVELOPE PROVIDED.
6. **DO NOT SUBMIT ANY ON-THE-JOB INJURY OR WORKERS' COMPENSATION CLAIM.**

TO BE COMPLETED BY THE EMPLOYEE

NAME (LAST, FIRST, MIDDLE INITIAL) | **SOCIAL SECURITY NO.**

HOME ADDRESS (STREET, CITY, STATE, ZIP CODE) **IS THIS A NEW ADDRESS?** ☐ YES ☐ NO | **WEEKLY WAGE**

DATE OF BIRTH | **TELEPHONE NUMBER** | ☐ **MALE** ☐ **FEMALE** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED**

NAME AND ADDRESS OF EMPLOYER

DO YOU HAVE MORE THAN ONE EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS.

DO YOU HAVE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO IF YES, GIVE NAME, RELATIONSHIP AND FULL NAME AND ADDRESS OF EMPLOYER.

IS THIS CLAIM FOR A DEPENDENT? ☐ YES ☐ NO IF YES, GIVE NAME, DATE OF BIRTH, RELATIONSHIP MARRIED? ☐ YES ☐ NO | **SPOUSE'S DATE OF BIRTH**

NATURE OF ILLNESS | **DATE OF FIRST TREATMENT**

IS THIS CLAIM BASED ON AN ACCIDENT? ☐ **YES** ☐ **NO IF YES, COMPLETE THE FOLLOWING:**

DATE OF ACCIDENT | TIME ☐ **AM** ☐ **PM** | **WHERE DID ACCIDENT OCCUR?**

HOW DID ACCIDENT HAPPEN?

HAS CLAIM PREVIOUSLY BEEN MADE FOR THIS PERSON UNDER THIS PLAN? ☐ YES ☐ NO

HAVE YOU (OR DEPENDENT) PREVIOUSLY BEEN TREATED FOR THIS OR A RELATED MEDICAL PROBLEM? ☐ YES ☐ NO IF YES, STATE WHEN AND GIVE NAME(S) AND ADDRESS(ES) OF DOCTOR(S) AND HOSPITAL(S)

ARE ANY OF THE ILLNESSES OR INJURIES FOR WHICH THIS CLAIM IS BEING MADE RELATED TO EMPLOYMENT? ☐ YES ☐ NO

IF YOU HAVE BEEN UNABLE TO WORK, GIVE DATE OF FIRST FULL DATE NOT WORKED ..... GIVE DATE OF RETURN OR EXPECTED DATE OF RETURN TO WORK .....

ARE YOU ENTITLED TO REIMBURSEMENT OF ALL OR PART OF THESE EXPENSES THROUGH ANY OTHER COVERAGE *WHICH PROVIDES* MEDICAL BENEFITS OR SERVICES? ☐ YES ☐ NO

IF YES, GIVE NAME AND ADDRESS OF ORGANIZATION PROVIDING BENEFITS OR SERVICES

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by the Administrator or its representative. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient's Signature if Claim is for dependent other than minor child .....

Dated ..... **Signature of Employee-Insured** .....

To authorize payment of benefits directly to your physician, complete authorization to pay benefits section on reverse side.

Administered by: ATPA

Health Insurance Claim Form

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME *(First name, middle initial, last name)*

4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*

5. PATIENT'S GENDER
MALE ☐ ☐ FEMALE

6. INSURED'S I.D. NO.

7. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. *(Or Group Name)*

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ ☐ NO
B. AN AUTO ACCIDENT
YES ☐ ☐ NO

11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I AUTHORIZE THE RELEASE O ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM
I declare and certify that the foregoing statements made by me are true to the best of my knowledge and belief. I am aware that if any of the statements made by me are willfully false I may be subject to criminal and civil penalties

SIGNED *DATE*

13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW*

SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ ☐ NO

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ ☐ NO

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE
1
2
3

☐ Check here if for Second Surgical Opinion

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER

26. YOUR SOCIAL SECURITY NO.

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

SIGNED DATE

30. YOUR EMPLOYER ID NO.

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & *TELEPHONE NO.*

32. ARE YOU BOARD CERTIFIED? ☐ YES ☐ NO

33. YOUR PATIENT'S ACCOUNT NO.

34. SPECIALTY

I.D. NO.

* PLACE OF SERVICE CODES

1 — (IH) — INPATIENT HOSPITAL
2 — (OH) — OUTPATIENT HOSPITAL
3 — (O) — DOCTOR'S OFFICE
4 — (H) — PATIENT'S HOME
5 — DAY CARE FACILITY (PSY)
6 — NIGHT CARE FACILITY (PSY)
7 — FREE STANDING SURGICAL CTR
8 — (SNF) — SKILLED NURSING FACILITY
9 — AMBULANCE
O — (OL) — OTHER LOCATIONS
A — (IL) — INDEPENDENT LABORATORY
B — IMMEDIATE CARE CENTER

EMPLOYEE CLAIM FORM AND ATTENDING DENTIST'S STATEMENT
EMPLOYEE SECTION

LOCAL UNION 831
EMPLOYER HEALTH & WELFARE TRUST FUND

Mail to: LOCAL UNION 831
P.O. Box 5528
El Monte, CA 91734
(626) 279-3080

NAME AND ADDRESS OF EMPLOYER | POLICY NUMBER

EMPLOYEE'S NAME (Last, First, Middle Initial) | EMPLOYEE'S ADDRESS (No., Street, City, State, Zip Code) Is this a new address? ☐ YES ☐ NO

EMPLOYEE'S DATE OF BIRTH | SOCIAL SECURITY NUMBER | CLAIM IS FOR ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD ☐ OTHER (Specify)

PATIENT'S GENDER ☐ MALE ☐ FEMALE | PATIENT'S DATE OF BIRTH | PATIENT'S NAME IF NOT EMPLOYEE

IF CHILD 19 OR OVER INDICATE ☐ HANDICAPPED ☐ STUDENT | IF STUDENT INDICATE NAME AND ADDRESS OF SCHOOL

ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF EMPLOYED FAMILY MEMBER

NAME AND ADDRESS OF HIS OR HER EMPLOYER

NAME AND ADDRESS OF HIS OR HER EMPLOYER'S INSURANCE CARRIER

IDENTIFICATION NUMBER OR POLICY NUMBER | IF BLUE SHIELD GIVE CERTIFICATE NO. | SUBSCRIBER NO.

I HEREBY AUTHORIZE RELEASE OF X-RAYS AND ANY OTHER INFORMATION RELATING TO THIS CLAIM
I declare and certify that the foregoing statements made by me are true, to the best of my knowledge and belief. I am aware that if any of the statements made by me are willfully false, I may be subject to criminal and civil penalties.

SIGNED _____
(Patient or Parent if Patient is a minor)

I HEREBY AUTHORIZE PAYMENT OF THE GROUP DENTAL BENEFITS OTHERWISE PAYABLE TO ME, DIRECTLY TO THE DENTIST NAMED BELOW.

SIGNED _____
(Patient or Parent if Patient is a minor)

DENTIST SECTION

BEFORE COMPLETING READ INSTRUCTIONS ON LAST PAGE FOR CLAIM SUBMITTAL & NECESSARY NOMENCLATURE & PROCEDURE CODES

DENTIST NAME | MAILING ADDRESS | CITY STATE ZIP

	NO	YES	IF YES ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
ARE ANY SERVICES COVERED BY ANOTHER PLAN?			

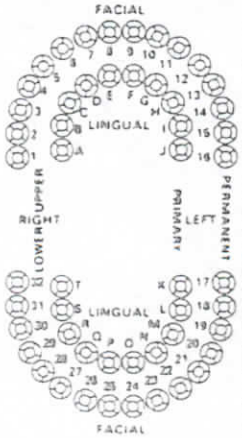
DENTIST SOC. SEC. OR T.I.N. | DENTIST LICENSE NO. | DENTIST PHONE NO.

IF PROSTHESIS IS THIS INITIAL PLACEMENT? | (IF NO REASON FOR REPLACEMENT) | DATE OF PRIOR PLACEMENT

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT OFFICE | HOSP | ECF | OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY? | IS TREATMENT FOR ORTHODONTICS? | IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED | MOS. TREATMENT REMAINING

CHECK ONE: ☐ DENTIST'S PRE-TREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES PERFORMED

IDENTIFY MISSING TEETH WITH X



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 – USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE	FOR ADMINISTRATION USE ONLY ☐ SCHEDULE %	☐ U&C %
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED (DENTIST) _____ Date _____

Administered by: A.T.P.A.

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

Statement of Claim for Group Vision Expense Benefits

LOCAL UNION 831 EMPLOYER HEALTH & WELFARE TRUST FUND

Mail to: LOCAL UNION 831
Employee Health & Welfare Trust Fund
P.O. Box 5528
El Monte, CA 91734
(626) 279-3080

PART 1. TO BE COMPLETED AND SIGNED BY THE PERSON CLAIMING BENEFIT FOR SELF OR DEPENDENT ONLY AFTER PART 2 HAS BEEN FULLY EXECUTED. (PLEASE PRINT)

Employee's Name (First) (Last)	Employee Date of Birth	Name of Company You Work For (Firm Name)
Home Address (Name and State)	Date Employed	Occupation
(City) (State) (Zip Code)	Employee's Telephone Number	Social Security Number

Claim is Made For	Name of Person Receiving Vision Care (First) (Last)	Person Receiving Vision Care: Male / Female	Year of Birth
☐ Self ☐ Spouse ☐ Child			

Name and Address of Spouse's Employer — Does Spouse have Vision Insurance? ☐ Yes ☐ No

Name of any other Insurance Carrier or Organization providing benefits for Vision Care including dependent's insurance.

Was Vision Care required because of an Injury? ☐ Yes ☐ No. **IF YES, COMPLETE QUESTIONS BELOW.**

Was injury caused by your work?	Have you filed a claim for this disability with the Workers' Compensation Carrier?	Is Vision examination required as a condition of your employment?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

The above answers are true and complete according to the best of my knowledge. I hereby authorize my doctor to furnish and disclose all facts concerning this disability. I certify that the examinations stated in PART 2 below have ben made, the materials described therein furnished, and professional services described therein rendered, all in a manner satisfactory to me.

I do / do not **hereby authorize payment directly to the undersigned doctor of the Vision Care benefits otherwise payable to me and to the supplying or dispensing optician for the ophthalmic materials and related charges according to the attached invoice.**

EMPLOYEE SIGN HERE

Date _____ Signature of _____

PART 2. TO BE COMPLETED BY DOCTOR

1. Has patient worn glasses before this examination? ☐ Yes ☐ No. Type _____ Date of Prev. Exam. _____
2. If Yes, state reason for replacement _____
3. Does your examination indicate that glasses should be prescribed? ☐ Yes ☐ No
4. If you prescribe glasses, check type: ☐ Single Vision ☐ Bifocal ☐ Trifocal
   Other (Describe) _____
5. Has cataract surgery been performed? ☐ Yes ☐ No. Date _____
6. Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? ☐ Yes ☐ No

	Date of Service	Charges $	Charges c
7. EXAMINATIONS			
A Vision Survey			
B Complete Visual Analysis (With Tonometry)			
C Complete Visual Analysis (Without Tonometry)			
8. MATERIALS & PROFESSIONAL SERVICES			
A Single Vision Lenses			
B Bifocal Lenses			
C Trifocal Lenses			
D Lenticular Lenses			
E Contact Lenses, for Each Lens			
F Frame			
G Case			
TOTAL			

Date Service Began _____ Date Service Completed _____

Doctor's Name _____

Doctor's Address _____

I hereby certify that examinations have been completed and materials and services rendered as stated in this Part 2.

Doctor's Signature X _____

Date _____

Taxpayers or Social Security Number

EMPLOYER'S STATEMENT

Plan No. _____

1. Effective Date of employee's coverage _____
   Effective Date of dependent's coverage _____
2. Has coverage terminated? ☐ Yes ☐ No. If yes, give date and reason _____ 19 _____

Dated _____ Signed for Employer _____ Title _____

SCL 007 (8/91)

Administered by: ATPA