Atlas Health Care Association

SUMMARY PLAN DESCRIPTION

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PLAN DOCUMENT

January 1, 2022

Amended, restated, and effective January 1, 2022

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IMPORTANT NOTICE TO ATLAS HEALTH CARE PARTICIPANT AND THEIR DEPENDENTS

The Board of Trustees of the Atlas Health Care Plan ("Plan") is pleased to present you with this fully updated Summary Plan Description ("SPD"). It describes the health and welfare benefit plans for Atlas Health Care Plan participants.

This booklet is both your SPD and Plan Document. The benefits you receive from this Plan are, in no small measure, regulated by the Employee Retirement Income Security Act of 1974 ("ERISA"). The Explanation of Coverage ("EOC") Statement that applies to your medical plan coverage is considered part of this SPD.

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

If you need additional information about your benefits, you may contact the Plan Administrator's Office by telephone at 1-855-422-8527. As a convenience to you, the Plan Administrator's Office will provide you with informal nonbinding responses to your questions over the phone. Oral answers supplied by the Plan Administrator's Office cannot change the written terms of the Plan. Nor are these informal responses binding on the Board of Trustees. Only the Board of Trustees has the authority to construe or to interpret the Plan. No individual Trustee, Plan Administrator's Office employee, employer, or union representative is authorized to understand the Plan on behalf of the Board of Trustees or to act as an agent of the Board. Benefits will be paid under this Plan only if the Board of Trustees decides, in its discretion, that the applicant is entitled to them.

This document does not serve as a guarantee of continued employment. The health and welfare benefits provided under this Plan are not vested. The Board of Trustees reserves the right to change, reduce or terminate this Plan or any of the Plan's benefits or rules at any time. From time to time, the Plan Administrator's Office may mail you updated material to inform you and your Dependents of any changes in benefits. Please read that information carefully and keep it with this booklet.

Yours very truly,

Atlas Health Care Plan and Trust

FOREIGN LANGUAGE NOTICE

This booklet contains a summary in English of your rights and benefits under the Atlas Health Care Plan. If you have any difficulty in understanding any part of this booklet, you may contact the Atlas Health Care Plan Administrator, P.O. Box 3257, Clovis, California 93613, 1-855-422-8527. Office hours are from 8:00 A.M. to 5:00 P.M. Monday through Friday.

Avisio En Español

Este folleto contiene un resumen en ingles de sus derechos y beneficios bajo el Atlas Health Care Plan. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con Atlas Health Care Plan Administrator's Office, P.O. Box 3257, Clovis, California 93613, 1-855-422-8527. El horario de atención de la oficina es de 8:00 a.m. a 5:00 p.m. de lunes a viernes.

I. INTRODUCTION

A. What This Document Tells You

This Summary Plan Description ("SPD") describes the benefits and the eligibility requirements for Active Employees and eligible Dependents of the Atlas Health Care Plan ("Plan" or "Health & Welfare Plan").

The attached Appendix includes the Confirmation of Coverage (COC) and the Schedule of Benefits (SOB) Statement.

The Plan described in this document is effective on January 1, 2022. It supersedes and replaces any previous plan, program, summary plan description, Plans rules, Plan amendments, policy, or practice, which may have provided Plan benefits.

Eligibility--To determine if you or your dependents are eligible for Plan benefits, please refer to the Eligibility Rules section in this document. Coverage for eligible dependents will be conditioned on your providing proof of dependent status, satisfactory to the Plan.

No Guarantee of Employment--Please understand that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.

The purpose of this SPD is to help you understand and enjoy the benefits provided to you by the Atlas Health Care Benefits Plan. Please review it and share it with your family covered by the Plan. This SPD provides a description of the Plan's benefits and the limits on available benefits. It tells you how to submit a claim for Plan benefits and how to appeal a denied claim. It also describes the eligibility rules as well as your responsibilities to promptly notify the Plan Administrator's Office upon the occurrence of certain events such as birth, adoption, marriage, domestic partnership, death, or divorce.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur is covered under the Plan.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information from the Plan Administrator. A Quick Reference Chart on page 4 highlights sources of support for acquiring specific information about each of the Plan's benefits.

The medical benefits of the Plan are self-funded with contributions from the Trust Fund (the Atlas Health Care Plan) held in a Trust that is used to pay Plan benefits. This document constitutes both the official Plan document and the required summary plan description under ERISA.

B. IMPORTANT: ALL PLAN BENEFITS ARE SUBJECT TO CHANGE

No Atlas Health Care Benefits Plan participant has a right to continue receiving the same Plan benefits as they exist now or have existed in the past. Plan benefits do not

vest. The Board of Trustees can change the Plan's interests at any time.
The Plan attempts to maintain financial reserves that are adequate to pay claims already incurred and claims likely to be born. Financial reserves are not retained for future eligibility of Active Employees. The Trust pays current benefit claims from ongoing contributions made by employers. The Trust will pay Plan benefit claims for so long as enough funds are available.

C. AUTHORIZED SOURCE OF INFORMATION

The source of authorized information for this Plan is contained in this SPD, the relevant SBC's and EOC's, the Trust Agreement, and the written statements of the Board of Trustees or the Plan Administrator. Statements or representations made by individuals other than those designated above are of no legal force or effect. Questions as to eligibility, Plan benefits, and other matters should be submitted in writing to the Plan Administrator located at P.O. Box 3257 Clovis, California 93613, 1-855-422-8527.

D. DISCRETIONARY AUTHORITY OF BOARD OF TRUSTEES AND ITS DESIGNEES

The Board of Trustees alone has the power to construe and interpret the Plan, the Plan's rules, contracts, and other documents establishing the Plan's benefits. The Board of Trustees' authority to explain the Plan includes, but is not limited to, determining who is eligible for Plan benefits, and the power to decide any factual question concerning the eligibility for any type or number of benefits. Benefits will be paid under this Plan only if the Board of Trustees decides, in its discretion, that the applicant is entitled to them.

Any delegation of authority by the Board of Trustees will carry with it the full discretionary authority to carry out the delegated duties. Any determination by the Board of Trustees or its delegate will be final and conclusive upon all persons.

1. Right to Delegate.

The Board of Trustees may, from time to time, allocate authority to one or more of its members or the Plan Administrator's Office's employees, directors, or agents. The Board may delegate authority to any person or organization and any of its respective powers, duties, and responsibilities for the operation and administration of the Plan. This includes, without limitation, the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claim, and the discretion to decide matters of fact and to interpret Plan provisions, Also, the Board of Trustees or its delegate may employ persons to render advice about Plan benefits, operation, administration, or fiduciary responsibility. Upon delegating responsibilities, the Board of Trustees will have no liability for the acts or omissions of any such designee if the Board of Trustees did not violate its fiduciary duty in making or continuing such delegation. All allocations and commissions of fiduciary responsibility will be terminable upon reasonable notice from the Board of Trustees.

E.

IMPORTANT NOTICE

You and Your Dependent(s) must promptly furnish to the Plan's Administrative Office information regarding change of name, address, marriage, divorce or legal separation, birth, adoption, death of any covered family member, change in the status of a Dependent Child, change in the status of a Domestic Partnership, Medicare enrollment or this enrollment, and or the existence of other coverage.

Notify the Plan no later than 30 days after any of the above-noted events.

Failure to give the Plan timely notice (as noted above) may cause you, your

Spouse, Domestic Partner and Dependent Child(ren):

a. to lose the right to obtain COBRA Continuation Coverage (or Cal-COBRA for Domestic Partners), or

b. may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or

c. may cause claims not to be able to be considered for payment until eligibility issues have been resolved, or

d. may result in your liability to repay the Plan if any benefits are paid for an ineligible person.

Again, IF YOU FAIL to notify the Plan properly, there are Consequences.

F. QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Plan Administrator's Office at the phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the Plan Administrator's Office staff may respond informally to oral questions. Again, please understand that verbal communications are not binding on the Plan and cannot be relied upon in any dispute concerning your Plan benefits.

The most reliable method is to put your questions into writing and email or mail those questions to the Plan Administrator's Office. The Plan Administrator will forward your item to the Board of Trustees for consideration at the next scheduled Board

meeting. In the event, there is a discrepancy between any information that you receive from the Plan Administrator's Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits. The Board of Trustees has the sole power and authority to interpret the terms of the Plan.

Plan Administrator
P.O. Box 3257.
Clovis, CA 93612

G. FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

Call This Department.	If You Have a Question about eligibility?	At This Number
Atlas Customer Service Department	Your bill or What services are covered under your plan	1-855-422-8527
Atlas Claims Department	The status of a claim or To request reimbursement for a covered charge that you paid	1-855-422-8527
Telemedicine	Accessing telemedicine services for yourself or your family members	1-800-611-5601
Discount Rx USA	Discounts on prescription medications, and for an alternative, please visit https://www.goodrx.com/	1-787-405-4085

H. IDENTIFYING PLAN INFORMATION

The Atlas Health Care Plan Board of Trustees maintains the Atlas Health Care Plan ("Plan") for the exclusive benefit of the Sponsoring Unions' members and their eligible dependents. Your Atlas Health Care Plan benefits are paid to you from the assets of the Atlas Health Care Plan Trust ("Trust"). Plan benefits, including information about eligibility, are summarized in the Schedule of Benefits which together with this document, constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act of 1974 ("ERISA").

Plan Name/Number: Atlas Health Care Benefit Plan/501

Type of Plan: Multiemployer health and welfare benefit plan.

Plan Year: January 1 to December 31

Plan Sponsor: Atlas Health Care Board of Trustees; Oasis Labor Alliance & Affirmative Employers Labor Benefit Union

Participants and beneficiaries may receive, upon written request, information as to whether a

particular employer or employee organization is a sponsor of the plan, and if the employer or employee the organization is a plan sponsor, the sponsor's address.

Plan Funding: Employer/Employee Contributions. Benefits under the Plan are provided through employer contributions to a multiemployer health and welfare trust.

Admin Type: Third Party – Affirmative Benefits LLC

Plan Sponsor's EIN: 82-1376607

Plan Administrator
P.O. Box 3257
Clovis, California 93613
1-855-422-8527

Board of Trustees:

Nick Kantar, Chairman
Victor Celis, Secretary
Humberto Avila, Chief Financial Officer

Principal Place of Business:

P.O. Box 3257
Clovis, California 93613

Service Agent:

The Agent is the Plan Administrator. A service of legal process may be made upon a plan trustee or the plan administrator.

Collectively Bargained:

The Atlas Health Care Benefits Plan is maintained according to a Collective Bargaining Agreement between Sponsoring Unions and Employers. Participants and may obtain a copy of the agreement beneficiaries upon written request and is available for examination.

I. MEMBER SERVICES DEPARTMENT

For answers to questions about your benefits, or other issues, feel free to contact the Atlas Health Care Plan's Member Services Department at 1-855-422-8527**.**

Call Member Services to:

- Check whether you are eligible to receive benefits;
- Find out your benefit level;
- Request any forms;
- Update the information on your **Enrollment Form** (address, phone number, dependents, etc.);
- Notify the Atlas Health Care Plan when you change Employers;

- Report any errors on your ID cards;
- Notify the Atlas Health Care Plan when you are on Workers' Compensation, Disability or FMLA leave; or
- Get the answers to any of your questions.

II. OVERVIEW

A. REMINDERS:

- You must be a member of a Sponsoring Union to be eligible for benefits.
- Check the information on your ID cards and notify the Atlas Health Care Plan of any incorrect information immediately.
- Fill out all forms completely and attach all the documents required. Otherwise, your claim may be delayed, or your benefits are denied.
- Notify the Atlas Health Care Plan of any change of address, phone number, dependents, etc.
- Notify the Atlas Health Care Plan when you change Employers for your coverage to continue.
- To protect your benefits, contact the Atlas Health Care Plan immediately if you are not working due to a Workers' Compensation, Disability, or FMLA leave.
- Notify the Atlas Health Care Plan of any change that will affect your right to COBRA continuation coverage

B. PRE-EXISTING CONDITIONS

The Atlas Health Care Plan has no pre-existing condition exclusions. A pre-existing condition is a medical condition, illness, or health problem that existed before you enrolled in the Plan.

C. OVERVIEW OF BENEFITS

The Plan provides eligible employees and their eligible Dependents with health benefits under the applicable requirements of federal laws, such as Employee Retirement Income Security Act ("ERISA") according to the bona fide Collective Bargaining Agreement.

The following is a quick reference guide that gives you an overview of your benefits. Do not rely on this chart alone. Please read the rest of this SPD for a full explanation of each allowance.

D. HOSPITAL CARE

Hospital benefits under this plan are limited.

E. EMERGENCY DEPARTMENT VISITS

Emergency Department benefits under this plan are limited.

F. PROGRAM FOR BEHAVIORAL HEALTH

1. Mental Health

- Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years, are offered once a year.
- Mental and Behavioral health outpatient services may be covered. Limitations and copays apply. Please reference the Schedule of Benefits for your plan for full details.

- Unlimited Mental and Behavioral health telemedicine visits are included with no limitations and zero out of pocket costs.

2. Alcohol/Substance Abuse

- Alcohol misuse screening and counseling, for adults and adolescents, are offered once a year.
- Unlimited Access to licensed alcohol and substance abuse counselors via telemedicine visits are included with no limitations and zero out of pocket costs.

G. SURGERY

Not covered.

H. MEDICAL SERVICES

- Treatment in a doctor's office, clinic, hospital*, urgent care*
- Well childcare for dependent child(ren)
- Immunizations
- X-rays and laboratory tests, preventative care only
- Ambulance services*

Participating Providers bill the Atlas Health Care Plan directly and accept the Atlas Health Care Plan's payment as payment in full.

Hospital, Urgent Care, and Ambulance services are limited, or not covered.

I. PRESCRIPTION DRUGS

No deductibles or copays

Use the Discount Rx USA card included with your membership materials to receive discounts of up to 85% or please check out https://www.goodrx.com/ on prescription medication coverage.

III. ELIGIBILITY RULES

A. ACTIVE EMPLOYEES

1. Initial Eligibility Requirements

Every Active Employee must complete and submit an enrollment form before the activation of any Atlas Health Care Plan and before the submission of any Atlas Health Care claim.

Enrollment Forms are available at the Plan Administrator's Office located at

P.O. Box 3257.
Clovis, California, 93612.

Please call 1-855-422-8527 if you need enrollment information.

Services may be delayed or denied to you or your dependents if you or your dependents

are not correctly enrolled.

B. WHO IS ELIGIBLE?
Atlas Health Care Benefits are available to full-time employee members of participating labor unions.

1. **<u>You</u>** are eligible to enroll in an Atlas Health Care Plan when

You are

- Employed Full Time-defined as 30+ hours per week

And you have

- Established Membership in a participating Labor Union--(you must have a signed union membership card on file)
- Satisfied your employer's waiting period (usually 30-60 days)
- Made your required monthly employee contribution

2. **<u>Your Dependents</u>**
maybe eligible to enroll in an Atlas Health Care Plan.
To determine whether your spouse and dependent child(ren) are eligible to participate in the plan, please read below.

<u>Your spouse</u> may be eligible for coverage as your dependent if:
- You and your spouse are legally married; and
- You have provided documents showing proof of your marriage when requested by the Atlas Health Care Plan.

<u>Your domestic partner</u> may be eligible for coverage as your dependent if,
- You have a Certificate of Registered Domestic Partnership, naming him or her as your domestic partner issued by your State of Residence; or
- You have a Certificate of Domestic Partnership naming him or her as your domestic partner issued by your City of Residence.

IMPORTANT!
If you and your spouse or domestic partner are legally divorced or legally separated, your spouse or domestic partner cannot enroll in the Atlas Health Care Plan.

The Plan Administrator reserves the right, in its sole and absolute discretion, to determine all questions relating to the eligibility of spouses.

<u>Your child(ren)</u> may be eligible for coverage as your dependent up to their 26th birthday if,
- They are your biological child(ren); or
- They are the biological child(ren) of your legal spouse or domestic partner; or
- They're your legally adopted child(ren) (coverage for legally adopted child(ren) starts from placement); or

- They are your foster child(ren); or
- They are your dependent child(ren) by court order; or
- You are their legal parent identified on their birth certificate; and
- You have provided updated information about your child's coverage under other benefit plans as requested by the Plan; and

The Plan also extends benefits to the dependent child(ren) placed with you for adoption under the same terms and conditions that apply in the case of a dependent child(ren) who are your natural child(ren).

Your Grandchild(ren) may be **eligible** for coverage as a dependent on your Plan if they are your dependents by court order.

Child(ren) With Disabilities if your child is disabled, as described in the list immediately below, coverage for your child may continue after age 26 if all the following additional conditions are met:

- There is no other coverage available from either a government agency or through a particular organization; and
- Your child is not married; and
- Your child became disabled before age 19; and
- You file an adequately completed **Disability Certification Form** with the Atlas Health Care Plan each year after your child reaches age 26. Your child is considered disabled if the Trustees determine in their discretion that your child cannot engage in any substantial gainful activity due to any physical or mental impairment that is verified by a physician. The physical or mental impairment is expected to last for a continuous period of no less than 12 months or to result in death.

Eligibility Rules for Dependent Child(ren) Whose Coverage is Ordered by a Court

The Atlas Health Care Plan will comply with the terms of any Qualified Medical Child Support Order ("QMCSO") as the term is defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The Plan Administrator will determine the qualified status of a medical child support order under the Atlas Health Care Plan's written procedures.

NOTE: Changes within your family that relate to eligibility must be reported to the Atlas Health Care Plan immediately and in no case more than 30 days after the date of the event.

Such changes include:

- Separation, divorce or death of a spouse; or
- Change in status of your dependent child(ren), such as the birth of a child.
- Please see the section titled: "Let the Atlas Health Care Plan Know of Any Changes" on page [12]

IV. HOW TO ENROLL IN THE ATLAS HEALTHCARE PLAN

To Receive Your Plan Benefits, You Must First Enroll

A. ESTABLISH INITIAL ELIGIBILITY

Once you have established Initial Eligibility, you will not be enrolled in the Plan until you have completed the Plan's Enrollment Form. You must be part of a bargaining unit that elected your Union to represent you for purposes of collective bargaining with your employer. An Atlas Health Care Plan Enrollment Application Form is available to you. Contact your HR Department or your Union Member Representative.

B. OBTAIN AN ATLAS HEALTHCARE ENROLLMENT FORM

Contact your Union Representative to get an Atlas Health Care Enrollment form by visiting your HR Director, or by calling the Member Services Department at 1-855-422-8527.

C. COMPLETE AN ATLAS HEALTHCARE ENROLLMENT FORM

Thoroughly and accurately complete the Atlas Enrollment Form. You will be required to provide information about yourself and your family, including:

- Your name;
- Your address;
- Your Social Security number;
- Your birth date;
- Your marital status;
- The names, birth dates, and Social Security numbers of each member of your family; applicants must sign and date the form.

Incomplete enrollment forms will not be processed. Each form must be filled in clearly and thoroughly. Submission of an incomplete form may result in delays and rejection of your application.

D. GATHER THE REQUIRED DOCUMENTS

Documentation Requirements

Spouse – To enroll your spouse, you must furnish a copy of your Marriage Certificate with the Plan's Enrollment Form. If you and your spouse divorce, you need to provide the Plan with a copy of your Divorce Decree.

Domestic Partner– To enroll your domestic partner, you must furnish a copy of your Certificate of Registered Domestic Partnership or Certificate of Domestic Partnership with the Plan's Enrollment Form. If you terminate, dissolve or nullify your domestic partnership, you need to provide the Plan with a copy of your Notice of Termination of Domestic Partnership.

Dependent Child(ren) – To enroll a dependent child, you must provide the Plan with a copy of the child's Birth Certificate, or other documentation deemed adequate by the Plan establishing proof of legal guardianship, foster parenthood, adoption or placement for approval, or QMCSO, whichever applies. Dependent child(ren) are covered up to age twenty-six (26).

E. SUBMIT THE COMPLETED ATLAS HEALTHCARE ENROLLMENT FORM

Submit the completed Atlas Healthcare enrollment form to your union representative or HR Director.

V. WHEN YOUR COVERAGE BEGINS

A. NEW EMPLOYEES

You may start receiving benefits from the Atlas Health Care Plan after:

- You are hired by a Contributing Employer already participating in the Atlas Health Care Plan;
- You have enrolled in the Atlas Health Care Plan; and
- You have completed the Waiting Period specific to your Employer, and your Employer has been obligated to make contributions to the Atlas Health Care Plan based on your employment for at least 30 consecutive days. However, in no event can the Waiting Period exceed the 90-calendar day maximum under the Affordable Care Act).

B. NEWLY ORGANIZED EMPLOYEES

You may start receiving benefits from the Atlas Health Care Plan after:

- Your Employer becomes a Contributing Employer participating in the Atlas Health Plan;
- You have enrolled in the Atlas Health Care Plan; and
- Your Employer has made contributions to the Atlas Health Care Plan based on your employment for at least 30 consecutive days.

C. WHEN YOU CHANGE JOBS OR RETURN TO WORK AFTER A LEAVE

If you stop working for one Contributing Employer and begin working for another Contributing Employer or return to work for a Contributing Employer after an unpaid leave of absence:

- **Within 45 days**, you will have no break in your coverage;
- **After 45 days but within six months**, your benefits will start 30 days after you have been working for your new Contributing Employer; or
- **After six months**, you must meet the same requirements as a new employee.

NOTE: You must let the Atlas Health Care Plan know that you have changed Employers or returned to work from leave for your coverage to begin again.

D. WHEN YOUR FAMILY IS COVERED

Coverage for your eligible spouse and your child(ren) starts at the same time; your coverage begins if they meet the requirements for eligibility.

E. WHEN YOUR SITUATION CHANGES

Let the Atlas Health Care Plan Know of Any Changes

Your claims will be processed faster — and you will receive your benefits more quickly — if the Atlas Health Care Plan has up-to-date information about you and your family. You must notify the Atlas Health Care Plan no more than 30 days from the date of the event when:

- You change employers
- You move;
- You get married;
- You have a new baby;
- Your child reaches age 26;
- You are divorced or legally separated;
- A child or family member becomes disabled;
- A family member covered by the Atlas Health Plan dies;

Complete an **Enrollment Change Form** and send it to the Atlas Health Care Plan's Member Services Department to update your information. Remember to send copies of all the documents needed by the Atlas Health Care Plan, including:

- Birth certificate(s);
- Adoption papers;
- A marriage certificate if you are adding your spouse;
- Your separation or divorce papers if you are legally separated or divorced; and
- Information that is required by the Atlas Health Care Plan.

An English translation certified to be accurate must accompany foreign documents.

Note About Newborn Child(ren):

New parents have 30 days to notify Atlas Health Care of the birth of a new baby. Per ACA requirements, new preventive medical services are covered under all Atlas Health Care Plans for the first 30 days. After this, parents must either add the new baby to their plan or secure other health coverage. To expedite payment of claims for your newborn child, provide the Plan with a birth certificate, Social Security number, and Coordination of Benefits (other health insurance) information if applicable. [to add your newborn to your plan, please call customer service and provide your new baby's birth certificate, social security number and a completed coordination of benefits form]

VI. YOUR ID CARDS

When you have enrolled in the Atlas Health Care Plan, and you are eligible for benefits, you will receive:

- **Two (2) Atlas Health Care ID Cards** within ten days after enrollment into the

Plan. Call the Atlas Health Care Plan's Member Services Department at 1-855-422-8527 if you have any problems with your ID card(s), including:

- You did not receive your card(s);
- Your card is lost or stolen;
- Your name is not listed correctly; or
- Your spouse's and child(ren)'s name(s) are not listed correctly.

NOTE: If you are no longer eligible for benefits, you may not use any ID card from the Atlas Health Care Plan. If you do, you will be personally responsible for all charges. Your ID card(s) are for use by you and your eligible Dependents only. To help safeguard your identity, please use the unique Member ID number that is included on your card(s) rather than your Social Security number when communicating with the Plan. You should not allow anyone else to use your ID card(s) to obtain Atlas Health Care Plan benefits. If you do, the Atlas Health Care Plan will deny payment, and you may be personally responsible to the provider for the charges. If the Atlas Health Care Plan has already paid for these benefits, you will need to reimburse the Atlas Health Care Plan. The Atlas Health Care Plan may deny benefits to you and your eligible Dependents. It may initiate civil or criminal actions against you until you repay the Atlas Health Care Plan. If you suspect that someone is using your Health Benefits ID card fraudulently, call the Atlas Health Care Plans office as soon as possible to report the alleged Fraud or Abuse at 1-855-422-8527.

VII. CONTACTING THE ATLAS HEALTH CARE PLAN

A. BY TELEPHONE

1. Call **Atlas Member Services at** 1-855-422-8527 if you have any questions about your benefits, the programs or services offered by the Atlas Health Care Plan, or any procedures that need to be followed. The staff will be pleased to assist you in getting any information you need.

- A list of Participating Providers in your area;
- A list of Star Healthcare Network hospitals;
- A list of Participating Pharmacies in your area;

2. Automated Patient Verification for medical providers 1-855-422-8527

3. Call the **Atlas Claims Department** 1-855-422-8527for questions and status updates on claims.

B. EMAIL

support@atlashealthcare.org may be used to submit questions, requests, or send required forms, documentation that are requested by the Plan.

C. INTERNET

ATLASHEALTHCARE.ORG may be used to download forms, documents, locate a provider, or submit questions through our contact form.

D. MAIL may be used to submit any questions, requests, or send required forms,

documentation that are requested by the Plan.

P.O. Box 3257.
Clovis, CA 93612

VIII. GETTING THE CARE YOU NEED

Your Atlas Health Care Plan contracts with Star Healthcare Network to access more than 5,000 hospitals, 1 million doctors, and 115,000 ancillary facilities nationwide and in Puerto Rico. "Network Providers" are independent practitioners who accept the Atlas Health Care Plan's payment as payment in full for most services. You can choose any doctor, hospital, or another healthcare provider that you want for your family's care in the Star Healthcare Network.

A. LOCATE A PARTICIPATING PROVIDER

1. Go to atlashealthcare.org
2. Click on PPO Network, and then Find A Doctor.
3. Click the Select Network Button. A dialog box will appear, choose "PHCS."
4. A new dialog box will appear. Find a list of Statements, Choose "Healthy Directions" Near the bottom of the list.
5. The dialog box will disappear. On the right side of the screen, enter your zip code.
6. Enter a search term "General," "Pediatrician," "Laboratory," etc.
7. Call the Plan if you are having difficulty locating a provider using the search tool 1-855-422-8527

B. THE ATLAS HEALTH CARE PLAN PAYS FOR YOUR BENEFITS. YOUR DOCTORS PROVIDE YOUR CARE

You decide on which physician or healthcare provider you and your family use. The Atlas Health Care Plan's Participating Providers are independent practitioners that do not provide services as agents or employees of the Atlas Health Care Plan. The Atlas Health Care Plan does not provide medical care. To maintain the highest standard of care, the Atlas Health Care Plan reviews providers' practice patterns and credentials. However, the Atlas Health Care Plan is not responsible for the decisions and actions of individual providers.

C. PARTICIPATING PROVIDERS

- Accept the Atlas Health Care Plan's payment as payment in full for most services;
- Are conveniently located near where you work or where you live;
- Our licensed physicians and practitioners, and in almost all cases, board-certified or board-eligible in their area of specialty; and
- Are affiliated with highly regarded institutions throughout the area.

If your doctor needs to refer you to a specialist or another ancillary healthcare provider, make sure that the provider is part of the Star Health Care Network of Participating Providers. Please follow instructions because out of network providers may not be covered. This difference could result in higher out-of-pocket costs for you. For help identifying In-Network doctors and other medical service providers near you, visit our website at atlashealthcare.org and refer to the instructions above, or call the

Plan at 1-855-422-8527.

D. WHEN YOU USE A NON-PARTICIPATING PROVIDER

You may go to any doctor or hospital you choose. However, the Plan will only pay for services provided by In-Network Providers.

E. USING YOUR BENEFITS WISELY

Questions?

If you have any questions, call the Plan's Member Services Department at 1-855-422-8527. The staff can help you understand what procedures you need to follow to protect your benefits.

F. DOCTOR VISITS

You and your family are covered for medical services provided in a doctor's office or clinic. A licensed medical provider must provide your care. Specialists must be board-certified or board- eligible in their area of specialty.

1. CHOOSE A PRIMARY CARE DOCTOR FOR COMPREHENSIVE CARE

A primary care doctor is an internist, family physician, or pediatrician who coordinates your care or care needed by your spouse or child(ren). Your primary care doctor gets to know you and your medical history sees you when you are sick and provides regular check-ups and immunizations. This way, he or she is aware of your overall health, and minor problems can be detected before they become serious illnesses. If you have a chronic condition such as diabetes, hypertension, or heart disease, your primary care doctor can oversee your care and help you manage your health.

2. PREVENTIVE CARE

Regular medical check-ups help to keep you and your family healthy. Benefits are provided for preventive care services, including:

- Periodic check-ups

Through regular exams, your doctor can detect problems early, when they are easier to treat.

- Immunizations

Immunizations help protect your child(ren) against infectious diseases and are required for admission into the public-school system.

- Well childcare

Your dependent child(ren) are covered for regular exams.

This plan covers limited services related to preventative care, office visits with your physician or specialist**, telemedicine services,

- Treatment in a doctor's office, clinic, hospital*, Emergency Department*
- Assessment and treatment via telemedicine
- Well childcare for dependent child(ren)
- Immunizations
- Allergy: Preventative Care only

•X-rays and laboratory tests, Preventative Care only
•Birth Control--(not including abortifacient drugs)

Physician office visits and specialist visit benefits are limited and vary according to the selected plan. Please see your plan's Summary of Benefits (SOB) for details.

X-RAY AND LABORATORY SERVICES

Benefits are provided for routine, preventative X-rays and lab services when performed:

- In your doctor's office (for a limited number of regular tests only);
- By an outside laboratory

To avoid out-of-pocket costs, contact the Atlas Health Care Plan at 1-855-422-8527 or visit our website at **atlashealthcare.org** for the listing and locations of Participating Providers.

G. HOSPITAL CARE AND HOSPICE CARE

1. Hospital Care

Hospital benefits under this plan are limited.

NOTE: No benefits will be provided for any claim that began before the date of your eligibility.

2. What is Not Covered

Hospitalization coverage (if included in your selected plan) is limited.

3. Payment to a Hospital

The Plan does not make payments directly to any hospital.

4. Hospice Care

The Plan does not cover Hospice Care.

H. EMERGENCY DEPARTMENT VISITS

Emergency Department Visits

The Plan does not make payments directly to any hospital Emergency Department.

1. WHAT IS NOT COVERED

Emergency Department coverage (if included in your selected plan) is paid directly to the plan participant in the form of a lump sum indemnity benefit. Therefore, the plan participant is free to use the benefit to pay any service as they see fit.

I. IF YOU NEED TO GO TO THE HOSPITAL

Services may be limited, please reference your plan details.

1. WHAT IS NOT COVERED

Hospitalization coverage (if included in your selected plan) is limited, please reference your plan details.

J. MATERNITY CARE

Services for maternity care are not covered.

K. AMBULANCE SERVICES

Services may be limited, please reference plan details.

L. GENERAL EXCLUSIONS (WHAT IS NOT COVERED)

The Atlas Health Care Plan does not cover:

- Cosmetic treatment;
- Experimental, unproven or non-FDA approved medications, procedures, facilities, equipment, drugs, devices or supplies;
- Custodial treatment;
- Infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cry sterilization and reversal of sterilization;
- Laboratory tests that are not FDA approved;
- Hospice Care;
- Treatment for illness or injury covered by Workers' Compensation;
- Acupuncture when administered by anyone other than a licensed medical physician;
- Private physicians when care is given in a governmental or municipal hospital;
- Charges above the Atlas Health Care Plan's Schedule of Allowances;
- Employment or return-to-work physicals;
- Treatments determined to be not Medically Necessary
- Habilitation therapies to the extent there is other coverage available from either a government agency or program through a unique organization;
- Charges related to refractions when performed by an ophthalmologist; and
- All general exclusions are listed in Section III.E.
- Surgeries.

M. WHAT IS COVERED

To be covered:

- See your plan's Summary of Benefits for covered services under your Plan.

N. PRIOR AUTHORIZATION

The Atlas Health Care Plan does not support prior authorization. See your plan's Summary of Benefits for covered services under your Plan.

NOTE: Emergency transportation and services may be limited, or not covered. Please reference plan details. Services provided by Out-of-Network providers are

not covered.

O. DURABLE MEDICAL EQUIPMENT AND APPLIANCES

The Plan does NOT cover rental of standard durable medical equipment such as hospital beds and wheelchairs.

P. SPECIFIC MEDICATIONS

Prescription Drug Discounts are provided by Discount Rx USA, or please visit https://www.goodrx.com/ as an alternative.

Members are encouraged to make use of the Discount card included with their membership materials to receive significant discounts on more top tier and specialty prescription medications.

Q. AMBULATORY SURGERY OR INPATIENT ADMISSIONS

Services may be limited, or not covered.

R. CERTAIN DIAGNOSTIC AND RADIOLOGIC TESTS

All radiological tests must be performed by a radiologist or a non-radiology provider within the specialty of your request.

S. VISION CARE AND HEARING AIDS

Vision Care

- One eye exam every two years **for a child(ren)**

T. PRESCRIPTION DRUGS

1. **Prescription Drugs**

A Prescription Drug Discount card is provided (Discount Rx USA) or visit https://www.goodrx.com/ as an alternative.

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U. WHEN DOES PLAN COVERAGE TERMINATE?

Your coverage and that of your Dependents will end on the earliest date shown below:

- The first day of the month following the nonpayment of the monthly premium;
- Retroactively and immediately when it is determined that a misrepresentation of facts has occurred;
- The first day of the month following the date on which you entered the full-time, active uniformed service, excluding service not exceeding thirty-one (31) days per year in the Reserve Armed Forces of the United States of America. The procedure for electing USERRA self-pay coverage is the same as the procedure for electing COBRA described below.
- The last day of the month in which the maximum month allowed for self-payment and COBRA continuation coverage has been reached; or

- the date a COBRA payment is not timely made or not made in the amount required; or
- the date of the Participant's death; or
- the date the Plan terminates;
- the date the Plan is amended to change the eligibility rules which causes you to lose eligibility; or
- The first day of the month following the Participant's 65th birthday

Under the requirements of the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when contributions and self-payment are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, and makes an intentional misrepresentation of material fact that is prohibited by the terms and conditions of the Plan.

A Dependent of an Active Employee Participant's eligibility for Plan benefits will terminate on
the earliest of the following dates:

When the employee's coverage terminates; or

When the Dependent ceases to qualify as an eligible Dependent, if the employee fails to notify the Plan Administrator that a Dependent is no longer eligible, the employee will be liable for the repayment of any claims paid on behalf of the ineligible Dependent.

II. COBRA CONTINUATION COVERAGE

"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. By law, if you and your dependents have health care coverage through the Plan and that coverage ends due to certain qualifying events, you may elect to continue your coverage for a specified time, depending on the reason you lose coverage. You are required to pay the full cost of coverage, plus an administrative fee of 2%, for continued medical coverage for you and any eligible dependents you wish to cover when you lose eligibility for employer-paid coverage. The Plan Administrator's Office is responsible for administering COBRA continuation coverage. All notices regarding COBRA continuation coverage should be sent to the Plan Administrator's Office. To continue coverage, you must pay the premium monthly. When you first enroll, you may choose a different plan under COBRA than the one in which you were registered when you lost eligibility. But once enrolled in your COBRA plan, you may change your plan selection only during an Open Enrollment period or following a change in status.

A. Qualifying Event

The following chart shows who is eligible for COBRA continuation coverage, under what circumstances — known as qualifying events — and how extended COBRA continuation coverage continues. Chart Needs to be Reconstructed

You must notify the Plan Administrator's Office of a divorce, legal separation, or a child's loss of dependent status within 60 days after the date of the qualifying event. If

you do not, your spouse, former spouse, or dependent child will lose the right to elect COBRA continuation coverage.

WHO	QUALIFYING EVENT	WHO IS ELIGIBLE FOR COBRA CONTINUATION COVERAGE	DURATION OF COBRA CONTINUATION COVERAGE
You	Have a reduction in earnings below the level required for eligibility (and have exhausted any extended eligibility under the Extended Coverage Program or other coverage extension options)	You and your covered dependents.	18 months*
	Are disabled at the time you become eligible for COBRA, or you become disabled within the first 60 days after COBRA continuation coverage begins	You and your covered dependents.	29 months**
	Die	Your covered dependents.	36 months
	Become divorced or legally separated from your spouse	Your covered spouse	36 months
Your Spouse and Dependent Child(ren)	Is no longer an eligible dependent (due to age limit, divorce or legal separation)	Your covered dependents.	36 months
	Is no longer an eligible dependent because of your death	Your covered dependents.	36 months
	Is disabled at the time COBRA continuation coverage begins or within the first 60 days after COBRA continuation coverage begins	Your covered dependents.	29 months

* 24 months if, as an active participant, you've had at least two years of earned eligibility in the last five years.

** You are required to provide proof of eligibility for Social Security disability benefits for the continuation of coverage for the additional 11 months.

Once a qualifying event occurs, and you notify the Plan Administrator's Office, you'll receive full details about COBRA continuation coverage, including the cost and duration of coverage. You must then notify the Plan Administrator's Office within 60 days of the date the notice is sent, or coverage is lost, whichever is later, if you want to elect COBRA continuation coverage. Once you select coverage, you'll have 45 days from the date you decided to choose COBRA continuation coverage to pay the initial monthly premium, retroactive to the time of the qualifying event. This 45-day grace period is required by law, and no extensions will be granted.

Premiums, which may change each year, will then be due monthly. If you fail to pay your premium within 30 days of its due date, your coverage will be terminated and won't be reinstated. This 30- day grace period is required by law, and no extension will be granted.

If you do not respond to the initial COBRA notice within 60 days, you'll no longer be eligible for COBRA continuation coverage.

B. Disability Extension of 18-Month Period of Continuation of Coverage

If you or your covered spouse or dependent child(ren) are determined by the Social Security Administration to be disabled, at any time during the first 60 days of COBRA continuation coverage, and you notify the Plan Administrator's Office in a timely fashion, you and your family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator's Office is notified of the Social Security Administration's determination within 60 days of the date of the decision and before the end of the 18 months of COBRA continuation coverage. If you fail to provide such notice within this timeframe, you won't be eligible for the disability extension. This notice should be sent to the Plan Administrator's Office. The cost of coverage during the disability extension is 150% of the cost of coverage if the disabled individual is covered.

C. Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the COBRA continuation coverage period, your spouse and dependent child(ren) can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse and dependent child(ren) if you die, get divorced, or legally separated or enroll in Medicare (Part A, Part B, or both) after your COBRA coverage has commenced. The extension is also available to a dependent child when that child stops being eligible as a dependent child.

In all these cases, you must make sure that the Plan Administrator's Office is notified of the
second qualifying event within 60 days of the game. Failure to provide the Plan Administrator's
Office with notice of a second qualifying event within the 60 days, will cause the coverage to terminate at the end of the 18 months.

D. What Happens to COBRA Coverage If I Become Entitled to Medicare?

If you have COBRA continuation coverage before you enroll in Medicare, your COBRA coverage may end. Please follow this instruction because the employer has the option of canceling continuation coverage when Medicare entitlement begins. The length of time your spouse receives coverage under COBRA may change when you enroll in Medicare. Ask the Plan Administrator's office about this before you leave your job.

If you elect COBRA coverage after you enroll in Medicare, you can keep your continuation coverage. When your group coverage ends, you and your dependents can get coverage under COBRA. However, you need to decide about when to enroll in Medicare Part B if you are not already eligible.

You may have chosen to delay enrollment into Medicare Part B upon Medicare eligibility if you or your spouse are actively working and are covered by an employer's group health plan (EGHP).

If you have Medicare Part A when your group health plan coverage ends, and you or your spouse are no longer actively working, it will be necessary for you to enroll in Medicare Part B, even if you choose to continue employer group health coverage under COBRA. Why? Coverage under COBRA is not due to current, active employment, which means your Medicare coverage will be primary. You have eight months from when the job ends, called a particular enrollment period, to enroll in Medicare Part B. If you do not enroll during these eight months, you may have to pay a Medicare Part B premium late penalty. Also, your coverage will be delayed. You will only be able to enroll in Medicare Part B during the general enrollment period (January through March), and your coverage will not begin until July.

Remember, you are not entitled to a Medicare Part B particular enrollment period when COBRA coverage ends.

E. Exercising Your COBRA Rights

Active Employee Participants who lose coverage as a result of a COBRA "qualifying event" can continue coverage by self-payment.

YOUR COVERAGE AND YOUR DEPENDENTS' COVERAGE WILL END AS OF THE
LAST DAY OF THE MONTH OF THE LAST MONTH IN WHICH YOU HAD AT LEAST
110 HOURS IN YOUR RESERVE ACCOUNT.

F. How to Elect COBRA Continuation Coverage

To preserve your rights under COBRA, you must meet specific notification, election, and payment deadline requirements.

Under COBRA, you or your Dependents must inform the Plan Administrator's Office in writing within sixty (60) days of a divorce or loss of dependent status. The Plan Administrator's Office will notify you of your loss of eligibility, and your employer is obligated to inform the Plan Administrator's Office of other qualifying events. However, you are encouraged to notify the Plan Administrator's Office of any qualifying event to assure prompt handling of your COBRA rights.

If you elect COBRA continuation coverage, you pay the full cost of coverage for you and your Dependents plus a 2% administration fee (102% of the value of the coverage to the Plan). This amount is established annually by the Board of Trustees. The premium rates will not change for twelve (12) months following a rate change unless the Board of Trustees revises the Plan.

Once the Plan Administrator's Office is notified of a qualifying event, it will send you information concerning your continuation options, including the necessary COBRA election forms. You will have **sixty (60) days** from the later of the date of the qualifying event or the time the COBRA notice is sent from the Plan Administrator's Office in which to make your selection. If you do not make your election within this **sixty (60) day** period, you will forfeit all rights to COBRA continuation coverage.

You have a maximum of **forty-five (45) days** from the date you mail your election form to the Plan Administrator's Office in which to submit your first payment. This first payment must retroactively cover any period after the date that coverage was terminated. The Plan is prepaid. Therefore, all subsequent payments are due on the 15th day of the month before the coverage month.

G. Important Eligibility Issues to Note for COBRA Coverage for Dependents

To elect COBRA coverage, you must be covered under the Plan on the day before the qualifying event. Child(ren) born, adopted, or placed with you for adoption during COBRA continuation coverage can be added to your COBRA coverage, as can a new spouse if you marry during your COBRA coverage period. However, such new Dependents do not experience a qualifying event if any of the above circumstances occur during your COBRA coverage.

Under federal law, your Domestic Partner and his or her eligible Dependents do not qualify for COBRA continuation coverage. Domestic Partners may, however, qualify for Cal-COBRA continuation coverage. Check your Certificate of Coverage or Explanation of Coverage for more information.

H. COBRA Notification Requirements

You and your Dependents are responsible for informing the Plan Administrator's Office of a qualifying event such as divorce, legal separation, or reaching an age limit. **A divorce or the termination of a Domestic Partnership is a COBRA qualifying event for your ex-**

spouse or ex-Domestic Partner. You must inform the Plan Administrator within sixty (60) days of the qualifying event or sixty (60) days from the date your coverage ends, whichever is later.

Your notification must be made in writing on a form that may be obtained, for no cost, by calling the Plan Administrator's Office at 1-855-422-8527. Notice can be provided by anyone acting on your or your Dependent's behalf. If you fail to provide advice within this period, you will not be able to elect COBRA continuation coverage. You must send notice of a qualifying event to the Plan Administrator's Office at the address listed on page 4.

The notice must contain, at a minimum, the name of the Participant and any spouse, domestic partner or Dependents seeking COBRA coverage, a description of the qualifying event, and the date on which the qualifying event occurred. If the notice is incomplete, you may be asked by the Plan Administrator to provide additional information.

If your Plan coverage ends because of death, termination of employment or because of reduced work hours, and the Plan receives timely notice of these events, you and your Dependents will receive information from the Plan Administrator regarding your COBRA coverage rights within thirty (30) days of any of these events. You and your Dependents will then have **sixty**
(60) days to elect COBRA coverage.

I. Notice of Unavailability of COBRA

If you or your Dependent provide the Plan Administrator with a notice of a qualifying event, second qualifying event, or a determination of disability by the Social Security Administration, and the Plan Administrator determines that you or you're Dependent are not entitled to COBRA coverage or extended COBRA coverage, the Plan Administrator will send you or your Dependent a notice that explain the reasons why you are not allowed to COBRA coverage. This notice will be sent to you within **fourteen (14) days** of receiving the initial notification of a qualifying event.

J. When COBRA Coverage Begins

If you choose COBRA coverage at any time during your 60-day election period, coverage will be retroactive to the date of the qualifying event. However, your COBRA coverage will not begin until you timely submit your COBRA payments retroactive to your qualifying event.

K. COBRA Payment Shortfalls

If you or your Dependents remit a timely monthly contribution to the Plan, but the payment is significantly less than the amount due, your COBRA coverage will be terminated immediately. The Plan considers any COBRA payment to be substantially less if it is short by $50 or 10% of the monthly COBRA payment, whichever amount is less.

For payments that are not significantly less than the amount due but are still short of the actual monthly COBRA payment, the Plan will notify you or your Dependent of the amount of the deficiency and permit you or your Dependent to pay the balance within thirty (30) days of the date of the notice of deficiency. You or your Dependent are responsible for

paying all deficiencies. If you do not receive such notification from the Plan Administrator's Office for payments not significantly less than the amount owed, your payment will be deemed to be sufficient payment for that month only and should not be understood to indicate that you can reduce your COBRA premium in coming months.

L. If You Decide *Not* to Elect COBRA

In deciding whether to elect COBRA continuation coverage, you should remember that if your group health coverage is not continued, it might affect your rights under the federal law as follows:

If you have more than 63 days without any health coverage, your next group health plan can impose pre-existing condition exclusions.

Your rights to purchase individual health insurance policies that do not impose preexisting condition exclusions may be limited if you forego continuation coverage in your group plan for the maximum time available to you.

You should also remember that you have the right to request special enrollment in another group health plan which might be available to you, (such as through your spouse's or domestic partner's employer) within thirty (30) days after the termination of your group health coverage if the loss of coverage is due to the qualifying events listed above. You will also have this same special enrollment right if you elect COBRA and continue coverage to the end of the period allowed.

M. Waiver of COBRA

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

N. Who Else Is Eligible For COBRA?

COBRA continuation coverage is also available to the following qualified beneficiaries:

Dependents who were covered under the Plan's health plans before the loss of coverage due to a qualifying event as described above; and

A child who is born to, adopted by or placed for adoption with a participant while you are covered under COBRA. You must notify the Plan Administrator's Office within 30 days of the birth, adoption, or placement for adoption. If you do not, the child will lose the right to be covered under COBRA.

If you continue your coverage under COBRA, you may also be able to cover your same-sex domestic partner as your dependent under Cal-COBRA if you pay the required premiums. However, your same-sex domestic partner will have no individual Cal-COBRA rights under this coverage.

O. When COBRA Continuation Coverage Ends

COBRA continuation coverage takes effect on the date of your qualifying event and continues until the earliest of the following:

- You fail to pay the initial COBRA premium within 45 days of the date you enroll for COBRA continuation coverage;
- You fail to pay subsequent premiums within 30 days of the due date;
- The 18-month, 24 months, 29-month or 36-month continuation period ends;
- For the extension for disability, the date the person is no longer disabled;
- The date you or your dependents become covered, after the time you or your dependents elect COBRA continuation coverage, under another group health plan if the other program doesn't impose any pre-existing condition exclusions on the qualified beneficiary;
- The date you or your dependents become enrolled in Medicare, after the time you or your dependents elect COBRA continuation coverage, or
- The Plan no longer provides group health care coverage.

If you have questions about your COBRA continuation coverage, contact the Plan Administrator's Office, or contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of EBSA offices are available through EBSA's web site at www.dol.gov/ebsa.

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

P. The California Continuation Benefits Replacement Act ("Cal-COBRA")

Cal-COBRA applies to employers that cover from two to nineteen employees. Cal-COBRA also refers to employers with more than 20 employees when an employee has exhausted his or her 18 months of Federal COBRA benefits. Under the Plan, qualified beneficiaries who elect Cal-COBRA continuation coverage are required to pay the coverage premiums plus a 10% administrative fee.

Cal-COBRA requires continuation coverage to be offered to covered employees, spouses, former spouses, domestic partners (same or opposite sex), and their dependent child(ren) when the group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, one with termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce, or legal separation from a covered employee; a covered employee's becoming entitled to Medicare and a child's loss of dependent status (and therefore coverage) under the plan.

While Cal-COBRA continuation coverage must be offered, it lasts only for a limited period. This booklet will discuss all these provisions in more detail.

Summary of Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered.

Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.

California Health Benefit Continuation

Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	36 months
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

Domestic Partners Rights under Cal-COBRA

Domestic Partners who are either same-sex or opposite sex, who have filed a Declaration of Domestic Partnership with the California Secretary of State and who meet the eligibility criteria under the State of California Family Code § 297 will be considered qualified beneficiaries. It may elect to enroll themselves and their eligible dependent child(ren) onto Cal-COBRA. (Apply if covered under the plan before the Qualifying Event date or loss of coverage date.)

FAMILY AND MEDICAL LEAVE ACT

The federal Family Medical Leave Act ("FMLA"), the California Family Rights Act ("CFRA") and a growing number of State laws provide that in certain situations, employers of fifty (50) employees or more are required to grant leaves of **up to three (3) months** to employees to:

- take care of family needs such as the birth and care of a newborn or newly adopted child,
- Consideration of an ill child or spouse,

- to address the needs of the household if one parent is called to active duty service in the military, or
- to care for your serious health condition.

You and your eligible Dependents will continue to be covered under this plan provided they are qualified when they leave began and produced the employer makes the required contributions during the leave. It is not the role of the Plan to determine whether a participant is entitled to FMLA leave with medical coverage. Any questions regarding entitlement to FMLA, CFRA, or other State required the employer must resolve to go.

To the extent that you are entitled to leave with continuing medical coverage, the Plan will provide continued coverage for up to three (3) months provided that the employer contributions required for coverage are made in a timely fashion to the Trust Fund. Rights under this section of the Plan are independent of your rights to COBRA continuation coverage in the event of a disability. However, a COBRA "qualifying event" may occur if you do not return to work upon expiration of your FMLA or CFRA leave, or if you give your employer notice that you do not intend to return to work after your leave.

EXPANDED FMLA LEAVE TO FAMILY OF MILITARY SERVICE MEMBERS

According to the National Defense Authorization Act for Fiscal Year 2008, two types of leave of absence are available to families of military personnel. During either of the following types of consent, you are permitted to continue all your medical coverage offered through the Plan, subject to the terms of the law.

Service Member Family Leave. An eligible employee who is the spouse, son, daughter, parent, or next of kin (i.e., nearest blood relative) of a covered servicemember is entitled to a total of 26 weeks of leave during 12 months to care for the service member. A covered servicemember is a member of the Armed Forces (including National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy (including on an outpatient basis) for a severe injury or illness. The injury or illness must have been incurred in the line of duty while on active duty, and it must be an injury or illness that may render the service member unfit to perform the duties of his/her office, grade, rank, or rating. For an employee taking this type of leave, along with FMLA for any other purpose (e.g., the birth of a child), the combined total leave required for one 12-month period is 26 weeks.

Leave for Qualifying Exigency. Employees may take up to 12 weeks of leave (in one 12-month period) for a "qualifying emergency" (as defined in regulations issued by the Department of Labor) arising out of the fact that the employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. This type of leave will be available once the Department of Labor issues final regulations.

CONTINUATION OF COVERAGE UNDER USERRA

If you take a military leave for 30 days or less, you will continue to receive health care coverage for up to 30 days, per the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If you take a military leave for more than 30 days, USERRA permits you to continue medical

coverage for you and your dependents at your own expense for up to **24 months. You must** give your employer advance notice (with exceptions) of the leave, and provided your total consent when added to any prior periods of military leave, does not exceed five years. Except as described in this section, your rights to self-pay under USERRA are governed by the same conditions described in the COBRA section of this SPD. Also, your dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE.

To qualify for continuation coverage during a period of military service, you must give your employer advance notice of your military service and elect and pay for continuation coverage. To be timely, you must apply for continuation coverage by completing an election form available from the Plan Administrator's Office within 60 days of entering uniformed service. If you elect continuation coverage, you must pay premiums in the same amount (not to exceed 102% of the full premium under the Plan), form, and manner as provided under COBRA. Instead of paying for continuation coverage, you may continue coverage during a period of military service until any reserve in your hour's bank is exhausted. Coverage through the Plan will be canceled if you depart for military service without giving advance notice to your employer, and without electing to continue coverage through this Plan promptly.

Your eligibility will be reinstated on the day you return to work or register for work with your Union or your last employer, provided such former Employee notifies a Contributing Employer of the intent to return to employment within:

1. Ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or
2. Fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty-one (181) days.
3. If the former Eligible Employee is hospitalized for or convalescing from any illness or injury caused by active duty, the time limits to apply for re-employment are extended to the end of the period necessary to recover, but in no case beyond two (2) years.

However, until you earn enough hours to regain eligibility as an Active Employee Participant, you must pay the cost of continuation coverage upon your return to employment. Alternatively, your coverage may be reinstated immediately if you still have a reserve in your Hour Bank upon your arrival to work.

Continuation of coverage under USERRA will terminate on the earliest of the following dates, as applicable:

1. the end of the period for which the last payment was made for coverage promptly;
2. an individual return to covered employment and becomes eligible under this Plan; or
3. the maximum continuation period has been exhausted.

During the first 18 months of coverage, your eligible dependents will have all COBRA rights, such as the right to elect additional months of coverage in the event of a second Qualifying Event or a Social Security disability determination. These rights do not apply during the last six months of the 24 months.

V. PRIVACY RIGHTS (UNDER HIPAA)

The health benefit options offered under the Plan use health information about you and your covered Dependents only to provide treatment, pay claims, and related functions. A copy of the Plan's Privacy Notice appears below.

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

A. Use and Disclosure of Health Information

The Plan may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA, for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

B. To Make or Obtain Payment

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

The Plan may also disclose health information over the telephone to your spouse, another family member, or a personal representative (such as a union business agent or employer representative), for purposes of making or obtaining information about treatment or claims, if you provide your written authorization to the Plan to speak to this person on your behalf.

C. To Conduct Health Care Operations

The Plan may use or disclose health information for its operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all Plan participants.

D. For Treatment

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

E. Treatment Alternatives

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

F. For Distribution of Health-Related Benefits and Services

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

G. Public Health Risks

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

- Control of disease, injury, or disability.
- Births and deaths.
- Child abuse or neglect.
- Medications or problems with products.
- Notifying people of recalls of products they may be using.
- Exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notifying the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

H. For Disclosure to the Board of Trustees

The Board of Trustees represents that adequate separation exists between the Plan and Board of Trustees so that Protected Health Information ("PHI") will be used only for Plan administration. No person under the control of the Board of Trustees has access to your PHI. The Plan may disclose your health information to the Board of Trustees for Plan or Trust Fund administration functions performed by the Board of Trustees on behalf of the Trust Fund and Plan. Such administration shall include but is not limited to the following purposes appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits, and Plan design. The Plan also may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from other health plans or modify, amend or terminate the Plan.

As a condition for obtaining PHI from the Plan and other insurers and HMOs participating in the Plan, the Board of Trustees agrees to:

- Use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.

- Require each of its subcontractors or agents to whom the Board of Trustees may provide PHI to agree to the same restrictions and conditions that apply to the Board of Trustees concerning PHI.

- Bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other employee benefit plans sponsored by the Board of Trustees.

- Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.

- Make your PHI available for purposes of your request for inspection or copying.

- Make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as are allowed under the Privacy Rule.

- Make available the information required to provide an accounting of disclosures under the Privacy Rule.

- Do its internal practices, books, and records relating to the use and disclosure of PHI available to the Plan and to the Secretary of the U.S. Department of Health and Human Services ("DHHS") to determine the Plan's compliance with the Privacy Rule.

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

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

I. When Legally Required

The Plan will disclose your health information when it is required to do so by any federal, state, or local law.

J. Organ and Tissue Donation

If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

K. To Conduct Health Oversight Activities

The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure, or disciplinary action. The Plan, however, may not disclose your health information

if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

L. In Connection with Judicial and Administrative Proceedings

As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such law or in response to a subpoena, discovery request or other lawful processes, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

M. For Law Enforcement Purposes

As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for specific law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

N. To Coroners, Medical Examiners, and Funeral Directors

The Plan may release your health information to a coroner or medical examiner. It may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release your health information to funeral directors as necessary to carry out their duties.

O. In the event of a Serious Threat to Health or Safety

The Plan may make consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, if it is believed that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the public. Any disclosure would be to someone able to help prevent the risk.

P. For Specified Government Functions

In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

Q. For Workers' Compensation

The Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

R. Authorization to Use or Disclose Health Information

Other than as stated above, the Plan will not disclose your health information without your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

S. Your Rights concerning Your Health Information

You have the following rights regarding your health information that the Plan maintains:

T. Right to Request Restrictions

You may request restrictions on specific uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to request restrictions, please contact the Plan Administrator's Office.

U. Right to Receive Confidential Communications

You have the right to request that the Plan communicates with you in a certain way if you feel the disclosure of your health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Plan only communicates with you at a specific telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Plan Administrator at the Plan Administrator's Office. The Plan will attempt to honor your reasonable requests for confidential communications.

V. Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Plan Administrator's Office. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

W. Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made if the Plan maintains the information. A request for an amendment of records must be made in writing to the Plan Administrator's Office. The Plan may deny the request if it does not include a reason to support the amendment. The petition also may be rejected, if the Plan did not create your health information records, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to change falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

X. Right to An Accounting

You have the right to request a list of disclosures of your health information made by the Plan for any reason other than for treatment, payment, or health operations. The request must be made in writing to the Plan Administrator's Office. The request should specify the period for which you are requesting the information. Accounting requests may not be made for periods going back more than six (6) years. The Plan will provide the first accounting you request during any 12 months without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the cost, if applicable.

Y. Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Privacy Notice at any time, even if you have received this Privacy Notice previously or agreed to accept the Privacy Notice electronically. To obtain a paper copy, please contact the Plan Administrator's Office.

Z. Duties of The Plan

The Plan is required by law to maintain the privacy of your health information and to provide to you this Privacy Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Privacy Notice and will provide a copy of the revised Notice to you within sixty (60) days of the change. You have the right to express complaints to the Plan and the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any objections to the Plan should be made in writing to the Plan Administrator's Office. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

AA. Contact Person

For any issues regarding patient privacy and your privacy rights, you may contact the Plan Administrator's office at 1-855-422-8527.

VI. HOW TO FILE A CLAIM

A. How to File a Claim for Medical Benefits

1. Claims for Doctor visits, specialist visits, and routine preventative care from providers in the Star Health Care Network may be submitted to our claims department by the participating provider directly.

   Participating providers should mail itemized bills, including diagnosis to:

   Atlas Claims Department
   P.O. Box 3257
   Clovis, CA 93613

   If you or your provider have a question about the claims procedure or need to check on the status of a claim, you may do so by calling the claims department at 1-855-422-8527 and ask to speak with a claim's representative.

2. To file a claim for reimbursement of a covered service that you paid for yourself, please call the claims office directly at 1-855-422-8527.

B. Decisions on Your Claim

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

C. Post-Service Claims

Filing a Claim
A request for payment or reimbursement for benefits is called a "post-service care claim" or a "claim," which may be submitted to the Atlas Health Care Plan in either electronic or paper form. The Atlas Health Care Plan needs to receive a claim form so that:

- Your doctor or healthcare provider can be paid; or
- You can be reimbursed if you paid your doctor or healthcare provider.

If You Use a Network Provider
Your doctor, hospital, or healthcare provider will submit the claim to the Atlas Health Care Plan.

If You Use an Out-of-Network Provider
The Plan does not reimburse claims from Out-of-Network providers.

It Is Very Important to File Your Claim with the Atlas Health Care Plan Promptly

WHEN BENEFITS MAY BE SUSPENDED, WITHHELD OR DENIED

You must provide the Atlas Health Care Plan with all the information, documents, or other material it needs to process your claim for benefits.

The Atlas Health Care Plan may be unable to process your claim if you, your spouse or your child(ren):

- Do not sign the "Assignment of Benefits" authorization that allows your benefits to be paid directly to your provider; or
- Do not allow the disclosure of medical information, medical records, or other documents and information when requested by the Atlas Health Care Plan. Benefits may be suspended, withheld, or denied for the recovery of all benefits paid:
    - That you were not entitled to receive;
    - That your spouse or dependent child(ren) were not entitled to receive;
    - For claims that you, your spouse or dependent child(ren) would otherwise be entitled to until full restitution (which may include interest and expenses incurred by the Plan) has been made for any fraudulent claims that were paid by the Plan; or
    - Was the subject of a legal claim against a third party and for which you

did not comply with the lien requirements outlined in III.O.

WHAT IS NOT COVERED (CONTINUED)

In addition to the various exclusions and limitations set forth elsewhere in this SPD, the Atlas Health Care Plan does not cover the following charges:

- Charges over the Atlas Health Care Plan's Schedule of Allowances;
- Fees for services provided and supplies or appliances used before you, your spouse or your child(ren) became eligible for Atlas Health Care Plan coverage;
- Charges for services covered under any mandatory automobile or no-fault policy;
- Those associated with any work-related accidental injuries or diseases that are covered under Workers' Compensation or comparable law;
- Expenses for care resulting from an act of war;
- To the extent permitted by law, charges related to an illness or accident/injury that was deliberately self-inflicted except where such illness or accident/injury is attributable to a mental condition or that resulted from the person committing an illegal act;
- Charges for services or materials that do not meet the Atlas Health Care Plan's standards of professionally recognized quality;
- Charges that would not have been made if no coverage existed or that neither you nor any of your dependents are required to pay. For example, the Atlas Health Care Plan will not pay for services provided by members of your or your dependent's immediate family;
- Charges made by your provider for broken appointments;
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis;
- Charges for procedures, treatments, services, supplies or drugs for cosmetic purposes, except to remedy a condition that results from an accidental injury that occurred while covered by the Atlas Health Care Plan;
- Charges for experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (see definition of "Experimental" in Section III.K under What is Not Covered);
- Charges for services, treatments, and supplies covered under any other insurance coverage or plan, or under a policy or law of any government agency or program, unless there is a legal obligation to pay;
- Charges for services that are not FDA approved for a condition;
- Costs that are unreasonable, excessive or that are beyond a provider's standard billing rate or beyond his or her scope or specialty;
- Charges for services that are not covered by the Atlas Health Care Plan, even if the service is Medically Necessary;
- Charges for services that are not Medically Necessary (see Section III.J);
- Charges related to interest, late fees, finance charges, court or other costs;
- Charges related to programs for smoking cessation, weight reduction, stress management and other similar programs that are not provided by a licensed medical physician or not Medically Necessary;
- Charges for infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cry sterilization and reversal of sterilization;

- Costs for claims submitted more than 90 days from the date of service;
- Charges for claims filed more than 12 months after the date of service;
- Charges related to an illness or accident/injury resulting from the conduct of another person, where payment for those charges is the legal responsibility of another person, firm, corporation, an insurance company, payer, uninsured motorist fund, no-fault insurance carrier or other entity;
- Charges for services that are custodial;
- Fees for services above or not in compliance with the Atlas Health Care Plan's guidelines, policies or procedures;
- Costs that are not itemized;
- Charges for over the counter, personal, comfort or convenience items such as bandages or heating pads (even if your physician recommends them);
- Fees for services which are not pre-approved under the terms of the Plan;
- Charges for claims containing misrepresentations or false, incomplete or misleading information; or
- Charges for invalid and obsolete CPT or HCPCS codes.

ADDITIONAL PROVISIONS

Nothing in this SPD shall be construed as creating any right in any third party to receive payment from this Atlas Health Care Plan. Fees shall not be made to a person who is:

- A minor (under age 18)
- Unable to care for his or her affairs due to illness, accident/injury, or incapacity. The payment shall be made to a duly appointed legal representative or to such a person who is maintaining or has custody of the person entitled to fees.

No legal action may be brought against the Atlas Health Care Plan or the Trustees until all remedies under the Atlas Health Care Plan have been exhausted, including requests for Administrative Reviews or appeals. No legal action may be brought against the Atlas Health Care Plan or the Trustees by providers as an assignee of you, your spouse, or your child(ren) after one year from the date of service. No legal action for benefits under this Plan or a breach of ERISA may be brought in a forum other than a federal court in California. Payments made by the Atlas Health Care Plan, which are not consistent with the Plan — as stated in this SPD or as it may be amended — must be returned to the Atlas Health Care Plan. No benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge. Any action by way of anticipating, alienating, selling, pledging, encumbering, or charging the same shall be void and of no effect. Nor shall any benefit be in any manner subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefit.

Notwithstanding the preceding, the Atlas Health Care Plan shall have the power and authority to authorize the distribution of benefits under the terms of a court order that it determines is a Qualified Medical Child Support Order, as required by applicable federal law. The Plan does not cover claims containing misrepresentations or false, incomplete, or misleading information. If a false or fraudulent claim is filed, the Plan may seek full restitution plus interest and reimbursement of any expenses incurred by the Plan. The Plan may suspend the benefits to which the participant and his or her dependent(s) would otherwise be entitled until full restitution has been made. The Trustees reserve the right to turn any such matter over to the proper authorities for prosecution

D. Concurrent Care Claims

Atlas Health Care does not support Concurrent review.

VII. DENIALS OF CLAIMS

If your claim or request is denied, the Plan will send you a letter stating the reason your claim was rejected and informing you of the steps you must take to appeal the denial. This letter is referred to as a "Notice of Adverse Decision." The notice will inform you of:

- Reason for the denial of your claim or request, about the Plan provision(s) that requires rejection of your complaint,
- any additional information that the Plan requires before it can make a final determination of your claim or request and an explanation of why the Plan needs the information,
- the steps you must take if you choose to appeal the denial, including the applicable time limits for submitting an appeal and your right to submit written comments, documents and other information relating to the claim,
- your right to request, free of charge, access to any copies of any records or documents that it has in its possession that are relevant to your claim,
- your right to request from the Plan a copy of any internal rule, guideline or protocol that it relied on to decide your claim,
- if your application is denied because of a lack of medical necessity or the use of experimental or investigational treatment, or other similar exclusion or limit, you will be provided free of charge an explanation of the scientific or clinical judgment for the determination as applied to the Plan or your claim, a description of the expedited review process if you were denied urgent care or urgent pre-authorization request, and
- Your rights under ERISA to bring a civil action following a denial of a claim on appeal.

REVIEW OF DENIED CLAIMS AND APPEALS OF DENIED CLAIMS

If you disagree with the reason(s) for denying your claim, you may appeal the decision to the Board of Trustees. To appeal a denied claim, send a written statement to the Plan Administrator's Office within **one hundred and eighty (180) days** of receiving a notice of adverse decision on your claim for benefits and request for pre-authorization. If you (or your authorized representative do not appeal the decision within **one hundred and eighty (180) days**, you lose your right to request the resolution and also your right to sue because you have not adequately exhausted the Plan's administrative remedies. If you have a good reason for failing to appeal a decision within the above period, you may file an appeal for up to one year after the denial, but you must show in your request that you had good cause for filing a

late petition.

Your written statement of appeal must describe in detail your claims for benefits and the reason why you believe your claim was improperly denied. Also, the report must include any documents you think are pertinent to your appeal (and were not already provided to the Plan with your original claim).

All claims will be decided at the next regularly scheduled meeting of the Board of Trustees of the Plan receives your appeal at least thirty (30) days in advance of the next Board Meeting. If your appeal is not received within thirty (30) days of the next Board of Trustees' meeting, your appeal will be decided at the second regularly scheduled Board of Trustees' meeting following receipt of your appeal. If the Board requires additional time because of exceptional circumstances, within sixty (60) days of receiving your request, the Plan will send you a notice extending the time to decide your appeal. Even with an extension of time, the Board of Trustees will not take longer than **one hundred and twenty (120) days** to resolve your request.

The Board of Trustees will decide on your appeal. In its discretion, the Board of Trustees and may appoint at least one Employer Trustee and one Union Trustee to hear your appeal, who will then make a recommendation to the entire Board of Trustees for final determination. The Board of Trustees will not defer to the Plan Administrator's initial adverse benefit determination. It will consider all comments, documents and records, and other information you timely provide, even if they were not received or viewed during the initial claim decision. The Board of Trustees' decision on your appeal will be made based on the record, including any additional documents and comments you provide.

VIII. THE DECISION ON APPEAL

After the Board of Trustees decides your appeal, they will send you a written notice of their decision, which will include:

1. the reasons for the decision and references to the Plan's rules that justify the decision.
2. A statement of your right to receive, upon your request and free of charge, access to and copies of all documents, records, and other relevant information.
3. The right to file a suit under section 502(a) of the ERISA guidelines.
4. if your claim is for medical benefits, you will be notified if an internal rule, guideline, or other similar criterion was relied on by the benefit carrier and will be provided with a copy of such regulation, guidance, or different standards free of charge at your request, and
5. If your claim is denied based on a medical necessity or other similar exclusion or limitations, at your request, you will be provided, free of charge, an explanation of how that exclusion or restriction and any clinical judgments apply to your medical circumstances, including information relating to medical or vocational experts whose advice was obtained on behalf of the benefits carrier in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

You will be notified of the Board of Trustees' decision on your appeal as soon as possible, but no later than five (5) days after the Board has made its decision.

DEFINITIONS

Active Employee or Active Participant

You are an Active Employee or an Active Participant if your continued participation in the Plan is based on the number of hours you work for a Participating Employer bound by a Collective Bargaining Agreement, which requires contributions to be made to the Atlas Health Care Plan on your behalf. You remain an Active Employee if you are on leave or otherwise not actively working provided that the Collective Bargaining Agreement requires your employer to continue to make contributions to the Trust Fund while you are on such leave. Such contributions are made.

Beneficiary

Person or persons you have designated to receive certain Plan benefits that are payable if you die.

Contributory Employer

Contributes to the Atlas Health Care Plan under the terms set by of a Collective Bargaining Agreement.

Domestic Partner

Individual(s) of the same sex or the opposite sex, who have filed a Declaration of Domestic Partnership with the California Secretary of State.

Legal Guardianship

The term "legal guardianship" refers to the court-ordered relationship between a child and a person other than the legal parent resulting in the termination of parental rights and the assumption of responsibility for the child by a non-parent guardian.

Maintenance Medications

Prescription drugs are otherwise covered under the terms of the Plan required to stabilize an illness or symptoms of the disease. Examples of maintenance medications include, but are not limited to, medicines taken for:

- Attention-deficit hyperactivity disorder ("ADHD") and attention-deficit disorder ("ADD"), depression, anxiety, insomnia, psychosis, or schizophrenia.
- Diseases of the central nervous system, including epilepsy or seizures, Parkinson's disease, dementia, Alzheimer's disease, or similar memory problems, etc.

- Diabetes, thyroid problems, or osteoporosis.
- Heart, circulatory or blood conditions including heart failure, high cholesterol, high blood pressure, stroke, heart attack, blood clots, anemias, etc.
- Respiratory or lung conditions, such as allergies, asthma, etc.
- Stomach, bowel, or digestive problems including ulcers, heartburn, or reflux disease, etc.
- Urinary or prostate problems including, enlarged prostate, etc.
- Conditions such as migraine headaches, gout, some types of arthritis, etc.
- Medications to treat conditions of the eye, such as glaucoma, etc.
- Skin or skin-related conditions such as acne, psoriasis, etc.
- Prevention of rejection of transplanted organs or tissues.
- Infectious diseases such as tuberculosis and viral infections such as HIV, hepatitis, etc.

Open Enrollment Period

With Atlas Health Care Fund and Trust, Open Enrollment is year-round. You may enroll at any time of any month. Your effective date of coverage will begin on the first day of the month that follows your enrollment. However, if you enroll after the 25th of any given month, your plan's effective date will be the 1st of the following month. The participant agrees to a contract length of one (1) calendar year beginning January 1st and ending December 31st. If the participant enrolls in the program after January 1st, the participant agrees that their benefits will expire on December 31st of the year they register. Benefits must be renewed by December 15th of every year for continued coverage. If benefits are renewed after December 15th, a lapse in coverage may occur.

Participating Employer

Any employer or successor in interest to such an employer that subscribes to the Trust Agreement and is obligated to contribute to the Plan contributes to the Plan and is accepted for Plan participation by the Board of Trustees.

Qualified Medical Child Support Order ("QMCSO")

Qualified Medical Child Support Order ("QMCSO") means 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, and which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Plan participant is eligible. The Plan must determine that the order is qualified under the terms of ERISA and applicable state law.

Trust Agreement

The Agreement and Declaration of Trust establishing the Atlas Health Care Health & Welfare Trust Fund and any modification, amendment, extension, or renewal thereof.

Trust Fund Administration Office or Fund Office

The office that performs the day-to-day administration of the Trust Fund and its benefit plans, and can be reached at P.O. Box 3257, Clovis, California 93612, 1-855-422-8527.

Trustees or Board of Trustees

Trustees or Board of Trustees means the Board of Trustees of the Atlas Health Care Plan.

Trustees

The Board of Trustees is composed of an equal number of Union and Employer Trustees. The Employers elect employer Trustees. The Unions choose union Trustees. The Trustees of the Atlas Health Care Benefits Plan:

Chair
Nick Kantar
P.O. Box 3257
Clovis, CA 93612

Trustee
Victor Celis
P.O. Box 3257
Clovis, CA 93612

Trustee
Humberto Avila
P.O. Box 3257
Clovis, CA 93612

Union

Sponsoring Unions: Oasis Labor Alliance & Affirmative Employers Labor Benefit Union

You

The Plan participant.

IX. OTHER PLAN PROVISIONS

A. NAME AND ADDRESS OF THE FUND AND THE PLAN

The Atlas Health Care Health & Welfare Board of Trustees sponsors the Atlas Health Care Plan.

P.O. Box 3257,
Clovis, California
93612
1-855-422-8527

B. PLAN BENEFITS AND THE SOURCE OF FUNDING

The Benefits provided under the Atlas Health Care Plan are financed entirely by contributions from employers under the Collective Bargaining Agreement between the employers and the Sponsoring Unions. The amount of the donation is determined through the collective bargaining process.

The Board of Trustees has no liability to any individual or entity to provide payment over and above the amounts contributed to the Trust Fund and available for such purposes.

C. TYPE OF PLAN

The Plan is an ERISA-regulated employee welfare benefit plan providing medical benefits for eligible employees and dependents. The benefits are maintained through monthly contributions from participating employers paid on behalf of eligible employees and their covered dependents according to a Collective Bargaining Agreement.

D. FUTURE OF THE FUND AND AMENDMENT OF THE PLAN

The Trust Fund and all the Plans it sponsors are established and maintained through the collective bargaining process. The Board of Trustees anticipates that the Plan under which you are covered will continue if the Collective Bargaining Agreements so provide or until the Board of Trustees decide to end the Plan or the Trust Fund.

The Board of Trustees reserves the right to change or discontinue any Plan at any time for any reason without the need for prior approval by any person, employer, or Union. Such amendments may change benefit levels, eligibility requirements – even if the extended eligibility has already been accumulated – or any other provision of the Plan.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim for the benefits occurs.

The Board of Trustees may update the Plan to reflect changes in laws and regulations as well as for any other reason. Any changes to the Plan will not lower amounts already payable for claims incurred before the Plan changes become effective.

Federal law prohibits the use of Trust Fund assets for any purpose other than providing benefits and paying the reasonable administrative expenses of the Trust Fund and the Plans

it sponsors. If the Trust Fund or Plan(s) end, the remaining assets will continue to provide Plan benefits until there are no more assets left or will be used in a way that is consistent with the purpose of the Plan or the Trust Fund. In no event will termination of the Plan and Trust Fund result in the reversion of trust assets to any employer.

Under regulations set forth by both the Affordable Care Act, Plan participants have the right to be notified 60 days before a material change in benefits. Material changes include the termination of a plan, addition or reduction in benefits, or elimination of interests within a plan. Upon receiving this notification, plan participants or beneficiaries must review their situation and determine their own best course of action, which may include seeking an alternate health care plan that better meets their needs.

E. DISCLAIMER OF LIABILITY

The Plan has no control over any diagnosis, treatment, care or lack thereof, or other services delivered to a Plan participant or Dependent by a health care provider (whether a Contract or Non-Contract Provider), and disclaims liability for any loss or injury caused to the Plan participant or Dependent by any provider because of negligence, failure to provide treatment or otherwise.

F. AUTHORITY TO INTERPRET PLAN

The Trust Agreement gives the Board of Trustees the authority to make any determination of fact necessary and proper to the administration of the Trust Fund and the Plan(s). It also gives the Board of Trustees the power to construe and interpret the terms of the Plan and the Trust Agreement relating to the eligibility of covered employees and retirees, their dependents, and beneficiaries to receive benefits. Benefits will be paid under this Plan only if the Board of Trustees decides, in its discretion, that the applicant is entitled to them.

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

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

All determinations made by the Board of Trustees concerning any matter arising under the Plan, this Summary Plan Description, and any other Plan documents shall be final and

binding on all parties. No employer, nor any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board of Trustees, nor can any such person act as an agent of the Board of Trustees.

G. BOARD OF TRUSTEES

The Atlas Health Care Plan is a health and welfare benefit plan which is jointly administered by Trustees who are responsible for the administration of the Plan. The names and addresses of the Trustees are as follows:

Union Trustees	Employer Trustees
Nick Kantar P.O. Box 3257, Clovis, California 93612	
Victor Celis P.O. Box 3257, Clovis, California 93612	
Humberto Avila P.O. Box 3257, Clovis, California 93612	

H. FUNDING OF BENEFITS

The benefits under the Plan are either self-funded or funded through group contracts between the Trust Fund and the third parties described in the chart below.

Type of Benefit	Name of Provider	Type of Funding
Medical Plan	Star Healthcare Network	Self-funded
Tele-Medicine	My-Telemedicine	Group contract
Prescription Drugs	Prescription Card Only	NA

In a breakdown of where incoming Atlas Health Care funds go:

1. 50% of every dollar goes to the claims trust
2. 21% goes to program reserves
3. And the remaining 29% goes to organizational operations

I. FUND'S EMPLOYER IDENTIFICATION NUMBER AND PLAN YEAR

The Trust Fund's Employer Identification Number ("EIN") assigned by the Internal

Revenue Service is 87-3544231, and its fiscal year is January 1 through December 31.

J. COLLECTIVE BARGAINING AGREEMENTS

The current Collective Bargaining Agreements between the Sponsoring Unions and the participating employers require the individual employers to contribute to the Trust Fund at the rate per hour prescribed by the applicable Collective Bargaining Agreement for hours worked by each of their employees upon covered employment. The parties to the Collective Bargaining Agreement are:

- [Employer Group Name], and
- Sponsoring Union.

A copy of the specific provisions of the Collective Bargaining Agreement applicable to Health & Welfare Benefits is available from either the Trust Fund Administration Office or Sponsoring Unions.

If you have a question of whether a specific employer is a sponsor of the Plan, you may request in writing the information from the Trust Fund Administrative Office.

K. AGENT FOR SERVICE OF LEGAL PROCESS

The Agent for Service of legal process on the Trust Fund is:

Plan Administrator
P.O. Box 3257
Clovis, California
93613

Service of legal process may also be made on the Board of Trustees or upon any member of the Board of Trustees.

L. ELIGIBILITY FOR PARTICIPATION AND BENEFITS

The Plan's requirements concerning eligibility as well as circumstances that may result in disqualification, ineligibility, or loss of benefits are described beginning on page 16 of this Handbook.

Contracts provide benefits with the following companies and service organizations:

- Medical Provider Network Access provided by Star Health Network
- Telemedicine Benefit provided by My Telemedicine Inc.
- Prescription Drug Discounts provided by Discount Rx USA or visit https://www.goodrx.com/ as an alternative.

M. REQUEST FOR INFORMATION AND DOCUMENTS

All requests for information and correspondence relative to coverage, benefits, and interpretation of the Atlas Health Care Plan and all claims for documents should be made in writing to:

Plan Administrator
P.O. Box 3257
Clovis, California
93613 1-855-422-
8527

N. YOUR ERISA RIGHTS

As a participant in the Atlas Health Care Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

O. RECEIVE INFORMATION ABOUT YOUR PLANS AND BENEFITS

- Examine, without charge, at the Administrative Office or, after proper written request, at the Union Hall, all documents governing the Plan, including third-party contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Any examination at the Administrative Office may take place between the hours of 10:00 AM and 3:00 PM PST Monday through Friday, except holidays.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including third-party contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with copies of these yearly summary reports.

P. PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

Q. ENFORCE YOUR RIGHTS

If your claim for a Health & Welfare Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within specific time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you

request a copy of the Plan document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. The court might require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the documents unless the documents were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and expenses. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

R. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator's 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 Administrative 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.

APPENDIX A

Please note: All Specialized Wellness (preventive care) related services have a maximum coverage of $200.

Services for Adults

BENEFIT	COVERAGE
1. Abdominal aortic aneurysm one-time screening for men of specified ages who have smoked	Once a year
2. Alcohol misuse screening and counseling	Once a year, adults
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages	As prescribed, aged 45-79, when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm of an increased in gastrointestinal hemorrhage
4. Blood pressure screening	Once a year, 18+
5. Cholesterol screening for adults of certain ages or at higher risk	Once a year
6. Colorectal cancer screening for adults over 50	Once a year ages 50-75 years
7. Depression screening	Once a year ages 18+
8. Diabetes (Type 2) screening for adults with high blood pressure	Once a year asymptomatic adult with sustained blood pressure (either treated or untreated) greater than 130/80 mm Hg
9. Diet counseling for adults at higher risk for chronic disease	Once a year, adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease

Services for Adults

BENEFIT	COVERAGE
10. Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B	Once a year
11. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945 – 1965	Once a year
12. HIV screening for everyone ages 15 to 65, and other ages at increased risk	Once a year, adolescents and adults at increased risk for HIV infection
13. Immunization vaccines for adults:	Once a year
Diphtheria	Once a year
Hepatitis A	Once a year
Hepatitis B	Once a year
Herpes Zoster (Shingles vaccine)	(2 shot series) Once per lifetime for patients over 50
Human Papillomavirus (HPV)	Once a year
Influenza (Flu Shot)	Once a year
Measles	Once a year
Meningococcal	Once a year
Mumps	Once a year
Pertussis	Once a year
Pneumococcal	Once a year
Rubella	Once a year
Tetanus	Once a year
Varicella (Chickenpox)	Once a year
14. Lung cancer screening for adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years	Once a year
15. Obesity screening and counseling	Once a year
16. Sexually transmitted infection (STI) prevention counseling for adults at higher risk	Once a year, sexually active adolescents and for adults at increased risk of STI

17. Syphilis screening for adults at higher risk	Once a year, persons at increased risk for syphilis infection
18. Tobacco Use screening for all adults and cessation interventions for tobacco users	Once a year, adults and pregnant women who use tobacco

Services for Pregnant Women/who may become Pregnant

BENEFIT	COVERAGE
1. Anemia screening on a routine basis	Once a year symptomatic pregnant woman
2. Breastfeeding comprehensive support and counseling from trained providers and access to breastfeeding supplies	Twice a year; to support parent(s) of the child once during the pregnancy and once postpartum.
3. Contraception: FDA-approved contraceptive methods, sterilization procedures, counseling, (not including abortifacient drugs)	As prescribed, FDA approved methods, sterilization procedures, not including abortifacient drugs
4. Folic acid supplements for women who may become pregnant	As purchased, women planning or capable of pregnancy
5. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes	Once a year, women 24-28 weeks pregnant and those at high risk of developing gestational diabetes
6. Gonorrhea screening for all women at higher risk	Once a year, sexually active women at increased risk
7. Hepatitis B screening for pregnant women at their first prenatal visit	Once a year
8. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	I time per year, pregnant women at 24-28 weeks' gestation unless the biological father is known to be Rh (D) negative
9. Syphilis screening	Once a year, persons at increased risk for syphilis infection
10. Expanded tobacco intervention and counseling for pregnant tobacco users	Once a year, adults and pregnant women who use tobacco
11. Urinary tract or other infection screening	Once a year

Other Covered Preventive Services for Women

BENEFIT	COVERAGE
1. Breast cancer genetic test counseling (BRCA) for women at higher risk	Once a year, women whose family history is associated with an increased risk for delirious mutations in BRCA 1 or BRCA 2 genes
2. Breast cancer mammography screenings every 1 to 2 years for women over 40	I time every two years, women 40+ years
3. Breast cancer chemoprevention counseling for women at higher risk	Once a year, women at high risk for breast cancer and low risk for adverse effects of chemoprevention
4. Cervical cancer screening for sexually active women	I time every five years, women 30-65 who want to lengthen the screening interval; screening with a continuation of pap smear and human papillomavirus (HIV) testing
5. Chlamydia infection screening for younger women and other women at higher risk	Once a year; women 24 years or younger and older non-pregnant women who are at increased risk
6. Domestic and interpersonal violence screening and counseling for all women	Once a year
7. Gonorrhea screening for all women at higher risk	Once a year, sexually active women at increased risk
8. HIV screening and counseling for sexually active women	Once a year, adolescents and adults at increased risk for HIV infection
9. Human Papillomavirus (HPV) DNA test every three years for women with typical cytology results who are 30 or older	Once a year
10. Osteoporosis screening for women over age 60 depending on risk factors	I time per year, women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65- year-old white woman who has no additional risk factors
11. Rh incompatibility screening follow-up testing for women at higher risk	Once a year
12. Sexually transmitted infections counseling for sexually active women	Once a year, sexually active adolescents and for adults at increased risk of STI
8. HIV screening and counseling for sexually active women	Once a year, adolescents and adults at increased risk for HIV infection
9. Human Papillomavirus (HPV) DNA test every three years for women with typical cytology results who are 30 or older	Once a year

Other Covered Preventive Services for Women (Continued)

BENEFIT	COVERAGE
10. Osteoporosis screening for women over age 60 depending on risk factors	I time per year, women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65- year-old white woman who has no additional risk factors
11. Rh incompatibility screening follow-up testing for women at higher risk	Once a year
12. Sexually transmitted infections counseling for sexually active women	Once a year, sexually active adolescents and for adults at increased risk of STI
13. Syphilis screening for women at increased risk	Once a year, persons at increased risk for syphilis infection
14. Tobacco use screening and interventions	Once a year
15. Well-woman visits to get recommended services for women under 65	Once a year, women only

Coverage for Children's Preventive Health Services

BENEFIT	COVERAGE
1. Alcohol and drug use assessments for adolescents	Once a year
2. Autism screening for children at 18 and 24 months	Once a year 18-24 months
3. Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Once a year, 0-17 years
4. Blood pressure screening for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Once a year, 0-17 years old
5. Cervical dysplasia screening for sexually active females	Once a year
6. Depression screening for adolescents	Once a year ages 12-18 years
7. Developmental screening for children under age 3	Once a year ages three years or younger
8. Dyslipidemia screening for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Once a year
9. Fluoride chemoprevention supplements for children without fluoride in their water source	Once a year
10. Gonorrhea preventive medication for the eyes of all newborns	Once a year, newborns
11. Hearing screening for all newborns	Once a year
12. Height, weight, and body mass index (BMI) measurements for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Once a year, ages 0-17 years
13. Hematocrit or hemoglobin screening for all children	Once a year
14. Hemoglobinopathies or sickle cell screening for newborns	Once a year
15. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11 – 17 years.	Once a year
16. HIV screening for adolescents at higher risk	Once a year, adolescents and adults at increased risk for HIV infection
17. Hypothyroidism screening for newborns	Once
18. Immunization vaccines for children from birth to age 18	Coverages vary according to recommendations based on age and population.
Diphtheria, Tetanus, Pertussis (Whooping Cough)	Once a year
Hemophilus influenza type b	Once a year
Hepatitis A	Once a year
Hepatitis B	Once a year

Coverage for Children's Preventive Health Services (Continued)

BENEFIT	COVERAGE
18. Immunization vaccines for children from birth to age 18 (Continued)	Coverages vary according to recommendations based on age and population.
Human Papillomavirus (PVU)	Once a year
Inactivated Poliovirus	Once a year
Influenza (flu shot)	Once a year
Measles	Once a year
Meningococcal	Once a year
Pneumococcal	Once a year
Rotavirus	Once a year
Varicella (Chickenpox)	Once a year
19. Iron supplements for children ages 6 to 12 months at risk for anemia	As prescribed, ages 6-12 months who are at increased risk for iron deficiency anemia
20. Lead screening for children at risk of exposure	Once a year, at-risk exposure
21. Medical history for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Once a year, ages 0-17 years
22. Obesity screening and counseling	I time per year ages 6-18 years
23. Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years	I time per year, 0-17 years
24. Phenylketonuria (PKU) screening for newborns	Once a year
25. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk	Once a year sexually active adolescents and for adults at increased risk of STI
26. Tuberculin testing for children at higher risk of tuberculosis ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years	Once a year ages 0-18 years
27. Vision screening for all children	One time every two years, ages 3-5 years