MULTI UNION SECURITY TRUST FUND
OPTIONS RIDER

Introduction

Multi Union Security Trust Fund is making health coverage easier than ever. The Multi Union Security Trust Fund OPTIONS Rider is designed to give you increased flexibility in your selection of outpatient services. This plan is specifically designed to complement your HMO coverage. It provides you and your covered family members the opportunity to receive selected outpatient services from any physician. It also covers some services that are not normally covered under your HMO benefit plan. The OPTIONS Rider is not meant to replace your HMO coverage and those services provided through your Primary Care Physician and selected hospital.

Benefits are limited to outpatient services such as physician office visits. Specifically excluded are inpatient services, major surgical procedures and maternity care in any setting. The Benefit Summary on the next page provides details about your coverage. You will note that there is a calendar year deductible and a benefit maximum for each covered family member. **All claims and required supporting documentation must be submitted within 15 months of the date of service. Claims and documentation submitted after such time period will not be considered.**

Here's How It Works

From time to time you may wish to obtain services for yourself or a covered family member from:

- physicians or other providers who are not participants in the HMO network.
- specialist physicians or other providers whom you wish to see without a referral.
- primary care physicians other than your own primary care physician.

You may also wish to obtain services that are not covered under your HMO benefit plan. The OPTIONS Rider provides you with this flexibility subject to the coverage described in the Disclosure Statement and Benefit Summary.

After you have received and paid for covered services, complete a claim form and provide your proof of payment to us. We consider any of the following to be proof of payment.

- canceled checks (photocopies of both sides);
- itemized medical bills indicating the amounts paid;
- patient account ledger(s) with your payment noted; and/or
- receipts in addition to itemized medical bills.

At the time of enrollment you will be provided with the necessary claim forms. If you have any questions regarding the claim form, proof of payment, or the need for additional claim forms, please call PacFed Benefit Administrators, Inc. at (818) 243-0222.

Options Rider Benefit Summary

Calendar Year Maximum $ 5,000

Individual Deductible $ 100 (Each covered individual must satisfy this deductible).

The Options Rider includes coverage for out of network physician and outpatient services, and specialized footwear that are Medically Necessary as outlined below. Inpatient services, major surgery and maternity care are expressly excluded. This Rider is offered only in conjunction with an HMO benefit plan.

For this Options Rider only, “Medically Necessary” means an intervention is *medically necessary* if, as recommended by the treating physician and determined by the health plan’s medical director, it is (all of the following): A health intervention for the purpose of treating a medical condition; the most appropriate supply or level of service, considering potential benefits and harms to the patient; known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion; and cost effective for this condition compared to alternative interventions including no intervention. “Cost effective” does not necessarily mean the lowest price.

Should claims that are “Medically Necessary” appear to be ambiguous or in dispute, the Trustees grant the Administrative Office the discretion to determine what is “Medically Necessary” for initial claims only. The Trustees retain this discretion with respect to all claims (other than the initial claims).

	Covered Expenses	Benefit Reimbursement
Out-of-Network Physician Services:	• Office Visits, including out-of-network Specialists (no referral necessary) • Preventive care for children • Minor Surgical Procedures (As defined in #6 of the Limitations & Exclusions section.) • Radiology • Pathology • Diagnostic tests (x-ray, labs) • Imaging (CT/PET scans, MRIs)	80% of charges not to exceed customary and reasonable amount
Out-of-Network Mental/Nervous Disorders and Alcohol/Chemical Dependency	Outpatient services, including: • Psychotherapy & counseling • Treatment of alcoholism & chemical dependency	80% of charges not to exceed customary & reasonable amount

	Covered Expenses	Benefit Reimbursement
Specialized Footwear	The Options Rider will cover specialized footwear, including foot orthotics, such as custom-made orthopedic shoes or custom molded orthotics, deemed to be Medically Necessary by a certified orthotist, certified prosthetist, or Medical Doctor for You and your Dependents. However, You and Your Dependents will not receive this benefit if you have diabetic foot disease and are covered by the plan of benefits provided by Anthem Blue Cross. When filing a claim for such specialized footwear, you must submit the original bill, indicating that the specialized footwear is Medically Necessary, and the notice from Anthem Blue Cross, declining coverage under its plan of benefits.	Up to a maximum of $500 per calendar year or as otherwise authorized by the Trustees towards the cost of the specialized footwear when considered to be Medically Necessary.
Additional Services	• Out-of-network Chiropractic • Out-of-network acupuncture services (including for dietary control when recommended by a licensed medical provider) • Out-of-network Podiatric Services	80% of charges not to exceed customary and reasonable amount

Limitations and Exclusions

The following are **not covered expenses** of the OPTIONS Rider:

1. Charges that are not included in the categories of "Covered Expenses" as defined in the chart above.
2. Charges for medical services, specialized footwear or any other services that are not Medically Necessary.
3. Charges for benefits that are provided by providers in your HMO benefit plans (currently Anthem BlueCross).
4. Charges for copayments, deductibles and/or coinsurance paid under your HMO benefit plan.
5. Charges for inpatient hospital services and for any other type of facility charges. Emergency room charges are not covered.
6. Charges for maternity care in any setting.
7. Charges for surgical procedures other than Minor Surgical Procedures. We consider Minor Surgical Procedures to be ones that:

- can be performed in a physician's office;
- do not require the services of an anesthesiologist or anesthetist;
- do not involve the use of an operating room or specialized surgical suite;
- do not result in professional charges in excess of $500 per procedure.

8. Charges for adult physical examinations.

9. Charges due to cosmetic, plastic or reconstructive surgery unless these conditions are met:
   a) the surgery must be required to remedy a condition that results from an injury or from a mastectomy or to correct a functional disorder as a result of a congenital defect; and,
   b) the surgery meets the criteria in number 6, above.
   Please note: We consider Rhinoplasty and Septoplasty to be cosmetic surgery, unless performed as a result of an injury.

10. Charges for:
    a) any of the following items including their prescription or fitting:
       i. hearing aids;
       ii. optical or visual aids, including contact lenses and eyeglasses;
       iii. wigs and hair transplants; and
       iv. disposable supplies for use by covered persons
    b) any examination to determine the need for or the proper adjustments of any item listed above.
    c) any procedure to correct refractive error.
    d) radial keratotomy.

11. Charges for items generally used for personal comfort and/or useful to the Covered Person's household, including but not limited to:
    a) all types of beds;
    b) air conditioners, humidifiers, air cleaners, filtration units and related apparatus;
    c) whirlpools, saunas and related apparatus;
    d) medical equipment generally used only by physicians in their work;
    e) vans and van lifts;
    f) stair lifts; and,
    g) exercise bicycles and other types of exercise equipment.

12. Charges for care, treatment, services or supplies that are primarily for dietary control (except for out-of-network acupuncture services when recommended by a licensed medical provider), including but not limited to any exercise programs:
    a) whether formal or informal, and
    b) whether or not recommended by a physician

13. Charges for dental work.

14. Charges for treatment of Temporomandibular Joint Syndrome ('TMJ").

15. Charges for testing, training, or rehabilitation for educational, developmental or vocational purposes.

16. Charges for treatment of a learning disability.

17. Charges made by a physician, surgeon, nurse or other practitioner who:
    a) normally lives with a Covered Person; or,

b) is a member of the Covered Person's family.

18. Charges incurred for home health care or hospice care.
19. Charges incurred for care or treatment of an intentionally self-inflicted injury.
20. Charges incurred for treatment with fertility drugs or artificial insemination and in-vitro fertilization including development and implantation of an embryo developed in-vitro).
21. Charges for telephone consultations.
22. Charges for in-network acupuncture.
23. Charges incurred by a Covered Person after he or she is no longer insured under the policy or by any coverage continued under the "Extended Benefit Provisions" or the policy.
24. Charges for which a Covered Person is entitled to payment under any local, state or federal Governmental agency including Medicare, but not MediCal.
25. Charges made by a hospital owned or run by the United State Government, with the exception of Veterans Administration Hospitals for non-service related charges.
26. Charges that in the absence of insurance would not be made; or charges for which there is no legal obligation to pay.
27. Charges for treatment:
    a) of an injury resulting from or due to any employment for wage or profit, unless the Covered Person does not qualify for coverage under any Workers' Compensation or similar laws; or
    b) sickness that is covered under any Workers' Compensation or similar laws.
28. Charges for injury or sickness resulting from any act of war, even if war has not been declared.
29. Charges resulting from non-therapeutic release of nuclear energy.
30. Charges for:
    - dress shoes and casual shoes, e.g. tennis shoes.
    - foot pads that are not custom-made;
    - foot orthotics that are not custom-made;
    - foot orthotics that are soft molded or made from cork and leather; and
    - socks or any supplies that are not custom made or of which its equivalent can be purchased without prescription as a standard shelf item.