TEAMSTERS WESTERN REGION & LOCAL 177 HEALTH CARE PLAN

SUMMARY PLAN DESCRIPTION/ PLAN RULES AND REGULATIONS

June 1. 2022

Teamsters Western Region & Local 177 Health Care Plan

Administrator: Southwest Service Administrators, Inc.
2550 W. Union Hills Drive Suite 250 Phoenix, AZ 85027-5163
● Phone: 855-215-2039 ● Fax: 602-324-0555 ● www.wr177healthcare.com

Dear Plan Participants:

This is the Summary Plan Description/Plan Rules and Regulations of the self-funded benefits of the **Teamsters Western Region and Local 177 Health Care Plan ("Plan)**. The Plan has been adopted for the exclusive benefit of Active employees of certain employers who participate in this Fund, and their covered Dependents.

This document describes the Medical PPO Plan including outpatient prescription drug, behavioral health and Employee Assistance Program (EAP) benefits. These Plan benefits are designed to help cover many of your expenses when you become sick or are injured. The Medical PPO Plan also provides an array of preventive/wellness services to help you and your family maintain good health and to help identify health risk factors that can, if not corrected, eventually lead to chronic diseases.

Here are some important tips on using your Medical PPO Plan, Dental PPO Plan, and Vision PPO Plan benefits:

- ✓ For an **overview of the benefits available** under the Teamsters Western Region & Local 177 Health Care Plan, refer to the various Schedules of Benefits. The Articles of this document that contain these Schedules are listed on the Table of Contents page.
- ✓ The Medical PPO Plan, Dental PPO Plan and Vision PPO Plan **allow you access to a network** of preferred health care providers. These in-network preferred providers give you a discount off their usual cost of services. **Using in-network providers will result in a substantial savings to you and to the Plan**.
- ✓ Because providers are added to or removed from the network each month, it is a **wise idea to check with the provider to see if they are still participating in the PPO network before you schedule an appointment or go get lab work or x-rays or other covered services**.
- ✓ **Certain services are recommended to undergo pre-approval** (also called precertification or prior authorization) before the service is performed. This includes certain medical plan services, certain outpatient prescription drugs and certain dental services. Precertification is discussed in the Utilization Management Article.

Notify the Administrative Office of any **address changes** to ensure that you receive updated Plan and COBRA self-pay information. Inform the Administrative Office of any **changes in the status of your Eligible Dependents** (for example, marriage, divorce, birth, child reaches the age of 26 years). Dependent child is defined in the Definitions Article. Important and helpful contact information is listed on the **Quick Reference Chart** in Article 2.

As Fund Trustees, we make every effort to administer the Trust carefully, making changes to your Plan as the Trust's financial condition changes and as mandated by law. Eligibility provisions may be modified in accordance with law and the collective bargaining agreements. Plan benefits may be increased or decreased (amended) from time to time and you will be notified if there are changes.

As always, we're here to serve you and your family, today, tomorrow and into the future.

Sincerely,

Board of Trustees

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ARTICLE 1: INTRODUCTION

What This Document Tells You.

This Summary Plan Description/Plan Rules and Regulations for the Teamsters Western Region and Local 177 Health Care Plan describes the Medical PPO Plan, Dental PPO Plan, Vision PPO Plan, and Short Term Disability benefits. It also provides information about the Death and Accidental Death and Dismemberment (AD&D) benefits of the Teamsters Western Region and New Jersey Health Care Fund. The Plan described in this document is effective June 1, 2022, and replaces all other plan documents, summary plan descriptions, plan rules/regulations and applicable amendments to those documents previously provided to Plan participants.

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility Article in this document. Coverage for eligible dependents will be conditioned on you providing proof of dependent status, satisfactory to the Plan.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. Receipt of this document does not guarantee eligibility for Plan benefits. No individual shall have accrued or vested rights to benefits under this Plan. (A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited.) Plan benefits are not vested and are not guaranteed.

This document will help you understand and use the benefits provided by **Teamsters Western Region and Local 177 Health Care Plan**. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this 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 get help or information. A Quick Reference Chart to sources of help and information about the Plan appears behind this Introduction in Article 2.

IMPORTANT NOTE

The Board of Trustees are committed to maintaining health care coverage for employees and their families at an affordable cost. However, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

The Medical PPO plan, Dental PPO plan, Vision PPO plan, Short Term Disability (STD) benefits and the Death and Accidental Death and Dismemberment benefits are self-funded with contributions from participating employers held in a Trust which are used to pay Plan benefits. Independent Claims Administrators pay benefits out of Trust assets. In Hawaii, New Jersey and New York, STD benefits are effected by a state law-mandated plan. The Fund reimburses that plan for the STD benefits for which is it responsible in those states. In California, for STD benefits, the Fund coordinates with a state law-mandated plan up to the plan benefit levels.

The Kaiser HMO Medical Plan (including outpatient prescription drugs) is fully insured and their contact information is listed under Medical HMO on the Quick Reference Chart in this document.

Suggestions For Using This Document.

This document provides detail about your Plan. We suggest that you pay particular attention to the following:

- Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the Definitions Article. The **Table of Contents** provides you with an outline of the Articles. The **Definitions** Article explains many technical, medical and legal terms that appear in the text.
- This document contains a **Quick Reference Chart** following this introductory text**.** This is a handy resource for the names, addresses and phone numbers of the key contacts for your benefits such as the Administrative Office or the Board of Trustees.

- The **Eligibility Article** outlines who is eligible for coverage and when coverage starts and ends along with your options (including self-payments) if coverage ends for you or a covered Spouse, or Dependent Child.
- Review the **Medical PPO Plan Benefits, Schedule of Medical Benefits for the PPO Plan and Medical PPO Plan Exclusions Articles.** These describe your benefits in more detail. There are examples and charts to help clarify key provisions and more technical details of the coverages.
- Review the **Utilization Management Article**. This Article describes how you can maximize plan benefits by following the precertification provisions.
- Review the **Dental PPO Plan Article** that includes information on the dental benefits payable by the Dental PPO Plan along with a **Schedule of Dental Benefits**. Review the **Vision PPO Plan Article** that contains details about the vision benefits of the Vision PPO Plan described in a **Schedule of Vision Benefits.**
- Refer to **Claim Filing and Appeal Information Article** tells you what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claim or eligibility decision.
- Refer to the **General Provisions Article** for information regarding your rights and information about ERISA. The Article on **Coordination of Benefits** discusses situations where you have coverage under more than one group health care plan, Medicare, another government plan, personal injury protection under mandatory no-fault automobile insurance coverage, workers' compensation, or where you can recover expenses from any other source.

Questions You May Have.

The Trustees realize that not all questions can be answered in this booklet, so you are urged to call or write the Administrative Office for help in understanding and obtaining the benefits to which you are entitled. If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Administrative Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the staff at the Administrative Office may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. If you contact the resources listed on the Quick Reference Chart in this document, as a courtesy to you, their staff may respond informally to oral questions.

Your most reliable method is to put your questions into writing and fax or mail those questions to the Administrative Office and obtain a written response from them. In the event of any discrepancy between any information that you receive from the Administrative Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

The Fund and Its Trustees.

The Teamsters Western Region and New Jersey Health Care Fund was formed as the Southwestern Teamsters Security Fund in the collective bargaining process in the early 1950's by and between various Teamster local unions in the southwestern United States and various employers in the grocery, delivery and warehouse industries. In mid-2014, UPS employees in New Jersey, parts of New York and in the Western United States were collectively bargained into participation in the Fund. Due to economies of scale and a mobile work force, the collective bargaining parties have designed the Fund as a "multi-employer" Fund so that workers for <u>all</u> the unionized employers in the industry could be covered by <u>one</u> health benefits program.

Under the multi-employer trust fund arrangement, industry employers make contributions to the Fund, in amounts required by the Collective Bargaining Agreements, on behalf of employees working under those agreements. These contributions are just a part of the overall wage/benefit package negotiated by the Teamsters Unions and the employers. The Fund's Board of Trustees, which consists of industry labor and management leaders, receives the contributions, holds them in trust to pay benefits and administrative expenses, and invests the reserves for the future. The Fund is <u>not</u> an insurance company that returns profits to its investors. The Fund uses <u>all</u> contributions and earnings either to provide benefits to employees and their dependents or to pay necessary expenses.

To clarify the work necessary for an employee to be eligible for benefits, and to specify the benefits available, the Board of Trustees has adopted Rules and Regulations governing the provision of benefits. These Rules and Regulations represent the efforts of the Trustees to provide the best benefits possible to the largest number of employees and dependents. The Rules and Regulations for the Teamsters Western Region & Local 177 Health Care Plan are set forth in this booklet.

Under the Collective Bargaining Agreements, the Agreement and Declaration of the Trust for the Fund, and the Rules and Regulations of the Plan, the Board of Trustees has full and exclusive authority to determine all questions of coverage and eligibility, the methods of providing or arranging for benefits and any other related matters. The Trustees have full power to construe the provisions of the Trust Agreement and the Rules and Regulations of the Plan. Any such determination and any such construction adopted by the Trustees in good faith is binding on the employers, the Unions, and any participant or beneficiary of the Fund.

The benefits in this booklet are not insured by any contract of insurance, and the responsibility for those benefits is limited to the amount in the Trust Fund collected and available for benefits purposes.

IMPORTANT NOTE

You or your Dependents must promptly furnish to the Administrative Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan preferably within 31 days, but no later than 90 days, after any of the above noted events. However, if notice of a COBRA qualifying event is not received by the Administrative Office within the required 60-day period (as discussed in the COBRA section in Article 3), the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Failure to give the Administrative Office a timely notice of the above noted events may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and vision plan benefits.

It is extremely important that you notify the Administrative office if you get divorced.

ARTICLE 2: QUICK REFERENCE CHART

QUICK REFERENCE CHART When you need information please check this document first. If you need further help, contact the resources listed in this Quick Reference Chart:	
Information Needed	**Whom to Contact**
Administrative Office • Short Term Disability benefit administration for all states (except HI, NJ and NY) and Level One and Level Two claim appeals • Administration of the Death benefit and Accidental Death and Dismemberment benefit and Death Benefit Appeals • COBRA Administrator • Medical PPO Plan Level Two Post-service Claim Appeals • Dental PPO Plan Level Two Post-service Claim Appeals • Eligibility for Coverage Level 1 and Level 2 appeals • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC)	**Southwest Service Administrators, Inc.** *Mailing Address*: 2550 W. Union Hills Drive, Suite 250 Phoenix, AZ 85027-5163 Phone: **855-215-2039** Fax: 602-324-0555 Email: custsrvcquestions@ssatpa.net Fund's website with benefits information: https://www.wr177healthcare.com/
Prescription Drug Program for the Medical PPO Plan's Outpatient Retail, Mail Order and Specialty Drugs • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Prior authorization/Precertification (medical review) of certain drugs • Specialty Drug Program: Precertification and Ordering • Information on drug quantity limits and step therapy • Direct Member Reimbursement (for Non-Network retail pharmacy use). Reimbursement form available on Fund's website at: https://www.wr177healthcare.com/ • Outpatient prescription drug claims and the following appeals: Level one post-service appeals and urgent, concurrent and pre-service appeals • ID cards	**CVS Caremark** Customer service and precertification of certain drugs: **(855) 305-3020** Specialty Drugs: **(800) 237-2767** Mail Order: **Caremark.com/startnow** CVS Caremark Claims Department Address: PO Box 52136 Phoenix, AZ 85072-2136

QUICK REFERENCE CHART

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

Information Needed	Whom to Contact
In-Network Providers for the Medical PPO Plan **Claims Administrators for the Medical PPO Plan** • Medical PPO Network Provider Directory • Mental Health and Substance Abuse Provider Directory • Medical PPO Plan Claim Forms • Medical PPO Plan Level one post-service claim appeals • For Kaiser HMO participants: the HMO Network Claims Administrator also is responsible for claims and appeals involving outpatient prescription drugs claims. See the Medical HMO row in this chart. • ID cards • Institute of Excellence (IOE) locations for transplants • Precertification for Medical, Mental Health, and Substance Use Disorder services (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price.) **CAUTION:** Use of a **non**-network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, or coinsurance) that exceed the Plan's payment for a covered service. (See definition of "balance billing" in the Definitions Article of this document). **Your lowest out of pocket costs will occur when you use In-Network providers**.	**For residents of Alaska, California, Idaho, Montana, New Mexico, Oregon, Pennsylvania, and Washington, the Medical Plan Network and claims administrator is:** **Blue Cross Blue Shield of Arizona** Phone: 844-899-4074 Blue Cross Blue Shield of Arizona P.O. Box 2924 Phoenix, Arizona 85062-2924 Website for National BlueCard Provider Directory http://provider.bcbs.com/ **For residents of Arizona, Hawaii, Nevada, New Jersey, New York, and Utah the Medical Plan Network is called the "Aetna Choice POS II." The network and claims administrator is:** **Aetna** 1-800-770-6803 or 1-888-982-3862 Website for providers: www.aetna.com/docfind For residents of California and Hawaii, you have the option of selecting from the applicable PPO network noted above or the Kaiser HMO plan, noted in the Medical HMO row of this chart.

QUICK REFERENCE CHART

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

Information Needed	Whom to Contact
Behavioral Health Program: **In-network Providers for Mental Health and Substance Abuse Treatment for the Medical PPO Plan and Claims Administration for Mental Health and Substance Abuse Services** • In-network providers for mental health and substance abuse services • Claims Administration for mental health and substance abuse services • Precertification and case management for mental health and substance abuse services • Urgent, concurrent and pre-service claim appeals • Behavioral Health Level One post-service claim appeals	**For residents of Alaska, California, Idaho, Montana, New Mexico, Oregon, Pennsylvania, and Washington, the Behavioral Plan Network and claims administrator is:** **Blue Cross Blue Shield of Arizona** Phone: 844-899-4074 Blue Cross Blue Shield of Arizona P.O. Box 2924 Phoenix, Arizona 85062-2924 Website for National BlueCard Provider Directory http://provider.bcbs.com/ **For residents of Arizona, Hawaii, Nevada, New Jersey, New York, and Utah the Behavioral Plan Network is called the "Aetna Choice POS II." The network and claims administrator is:** **Aetna** 1-800-770-6803 or 1-888-982-3862 Website for providers: www.aetna.com/docfind For residents of California and Hawaii, you have the option of selecting from the applicable PPO network noted above or the Kaiser HMO plan, noted in the Medical HMO row of this chart.
Member Assistance Program (MAP); **Employee Assistance Program (EAP) as provided by UPS** • Professional confidential support and referral at no cost to help individuals cope with personal problems that impact their home and work life. • EAP counselors can help with stress, marriage/family/work-related problems, substance abuse, financial and legal problems.	**Aetna Resources for Living EAP** Phone: 877-374-2779 Website: www.resourcesforliving.com Login: UPS Password: RFL

QUICK REFERENCE CHART

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

Information Needed	Whom to Contact
98point6 Virtual Care Solution • 98point6 is an on-demand, primary care text-based service delivered via secure in-app messaging on your mobile phone. • With 98point6, you will have access to U.S.-based, board-certified physicians to answer questions, diagnose and treat, outline care options, order prescriptions and labs as appropriate, and refer you to specialists and resources, all through the convenience of one app. • **Doctors are available 24/7/365.** You can get care from anywhere – during a break at work, while outdoors, or over lunch. No appointment, no travel, no waiting. • With 98point6, **the cost per visit is $0.** Prescriptions or labs received will be processed and billed in accordance to your medical plan benefits.	**98point6** Phone: 1-866-657-7991 Website: www.96point6.com Mobile App available to download from the Apple App Store and Google Play or www.96point6.com **Remember, in an emergency, call 911.**
Utilization Management (UM) Company for the Medical PPO Plan • You must request precertification (pre-approval) of certain medical plan services if using an out-of-network provider, such as a hospital admission, and home health care services in order to avoid a financial penalty. See Article 6 for details on precertification. • Urgent, Concurrent and Pre-service appeals	**For residents of Alaska, California, Idaho, Montana, New Mexico, Oregon, Pennsylvania, and Washington, to precertify call:** **Blue Cross Blue Shield of Arizona (BCBSAZ)** 844-899-4074 www.azblue.com **For residents of Arizona, Hawaii, Nevada, New Jersey, New York, and Utah to precertify call:** **Aetna** 1-800-770-6803 or 1-888-982-3862
Dental PPO Plan • Dental PPO Network (Dental PPO Provider Directory) • Dental PPO Plan Claims Administrator • Dental PPO Plan benefits information • Urgent, concurrent and preservice claim appeals • Level One dental post-service claim appeals	**Aetna Dental** Customer service: 1-877-238-6200 Precertification of certain dental services: 1-877-238-6200 Website for dental providers: www.aetna.com
Vision PPO Plan (when enrolled in the Medical PPO plan) • Vision PPO Network (Vision PPO Provider Directory) • Vision PPO Plan Claims Administrator • Vision PPO Plan benefits information • Vision PPO Plan post-service claim appeals	**Vision Service Plan (VSP)** 3333 Quality Drive Rancho Cordova, CA 95670 Phone: 800-877-7195 Website for vision providers: www.vsp.com

QUICK REFERENCE CHART

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

Information Needed	Whom to Contact
Medical HMO Plan (Insured) • The HMO plan includes medical plan benefits and outpatient prescription drug benefits • Participants who have elected the HMO option will have their behavioral health benefits provided by and administered by the HMO network in their geographic region. • Medical HMO benefits are not described in this document. For benefits information on the Medical HMO Plan, contact Kaiser Permanente HMO or visit the Fund's website.	**Kaiser Permanente HMO** **In Hawaii**: OAHU: 1-808-432-5955 Neighbor Islands: 1-800-966-5955 **In California:** 1-800-464-4000 Website for Kaiser providers: www.kp.org
Short Term Disability (STD) benefits for residents of all states, except Hawaii, New Jersey and New York • Short Term Disability Claims Administration • STD Disability claim form and instructions for filing for STD benefits (on the website or call the administrator) • Level One and Level Two claim appeals for disability benefits	**Southwest Service Administrators, Inc.** *Mailing Address*: 2550 W. Union Hills Drive, Suite 250 Phoenix, AZ 85027-5163 Phone: 855-215-2039 Disability Fax Line: 602-324-0553 For Workers Comp Leaves of Absence, contact UPS Human Resources Center (HRSC): 1-855-877-4772. custsrvcquestions@ssatpa.net
Short Term Disability (STD) benefits for residents of these states: Hawaii, New Jersey And New York • Short Term Disability Insurance Company (claims and Level One appeals)	**The Hartford** The Hartford disability representative: 1-866-825-0186 go to https://abilityadvantage.thehartford.com and use your UPS ID to register Additionally, you may submit documents via facsimile at 1-833-357-5153 or by email at GBIinformationUpload@thehartford.com.
COBRA Administrator • Information About COBRA Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Social Security Disability Notification	**Southwest Service Administrators, Inc.** *Mailing Address*: 2550 W. Union Hills Drive, Suite 250 Phoenix, AZ 85027-5163 Phone: 855-215-2039 Website: custsrvcquestions@ssatpa.net

QUICK REFERENCE CHART

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

Information Needed	Whom to Contact
Death Benefit and Accidental Death and Dismemberment (AD&D) claims administrator • Death benefit for employees and dependents and beneficiaries • Accidental Death and Dismemberment benefits • Level One and Two claim appeals for Death benefit, Accidental Death and Dismemberment, and Dependent Death benefits	**Southwest Service Administrators, Inc.** *Mailing Address*: 2550 W. Union Hills Drive, Suite 250 Phoenix, AZ 85027-5163 Phone: 855-215- Fax: 602-324-0555 Website: custsrvcquestions@ssatpa.net
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**HIPAA Privacy/Security Officer for the Teamsters Western Region and Local 177 Health Care Plan** 2550 W. Union Hills Drive, Suite 250 Phoenix, AZ 85027-5163 Phone: 855-215-2039 Website: custsrvcquestions@ssatpa.net
Plan Administrator/Plan Sponsor	**Board of Trustees of the Teamsters Western Region and Local 177 Health Care Plan** *Mailing Address*: 2550 W. Union Hills Drive, Suite 250 Phoenix, AZ 85027-5163 Phone: 855-215-2039 Website: custsrvcquestions@ssatpa.net

ARTICLE 3: ELIGIBILITY AND SELF-PAYMENT

HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED AND ENDS

This Article outlines the Weekly eligibility rules and the Self-payment rules.

Weekly Eligibility.

Some employees participate in the Plan on a monthly basis. Eligibility rules for those employees are expressed in a separate agreement which will be provided to those employees.

For all questions regarding eligibility, including eligibility for the Retired Employee coverage of the Fund, contact the Administrative Office (contact information on the Quick Reference Chart in the front of this document).

1. **General Eligibility Rule:**

   You are covered for benefits under this Plan only during periods when you have contributions reported to the Plan by your employer. To be eligible for benefits, you must have a contribution reported for the week services are received. The contribution week begins on Sunday.

   For a **new employee**, you are eligible for the health benefits as described in this document after you establish initial eligibility.

2. **Definitions Specific to Weekly Eligibility.**

   a. **Full Time Employee:** A Full Time Employee is an employee who is regularly scheduled to work a full work-week for a Contributing Employer and who is so identified by the Contributing Employer. This is not equivalent to full-time status under the Affordable Care Act.

   b. **Part Time Employee:** A Part Time Employee is an employee whose regular work schedule is less than a full work-week for a Contributing Employer and who is so identified by the Contributing Employer.

   c. **Seniority Attainment Date (SAD):** A Full Time Employee's Seniority Attainment Date (SAD) is the date on which the employee obtains seniority rights under the terms of a Collective Bargaining Agreement. An Employee's SAD will be identified by the Contributing Employer.

   d. **Eligibility Week:** An Eligibility Week is from 12:00 a.m. on Sunday through 11:59:59 p.m. the following Saturday.

   e. **Compensable Time:** Compensable Time is any time for which a Full Time Employee or a Part Time Employee receives compensation from a Contributing Employer.

3. **Initial Eligibility Establishment and Maintenance.**

   a. Contributions for **Full Time Employees** begin with the week for which the Employee is paid Compensable time that is coextensive with or follows the Employee's Seniority Attainment Date. Such contributions are due for each week thereafter for which the Employee was paid Compensable Time.

      Full Time Employees become eligible for the Eligibility Week following the date on which **eight (8) weeks** of contributions have been made on their behalf within a **26-week** period.

   b. **Part Time Employees** will receive contributions on their behalf from a Contributing Employer for each week for which the Employee was paid Compensable Time beginning with the **earlier** of:

      1) The 31st week of their employment in a Part Time classification; or

      2) 90 days after their completion of 1,200 hours of employment in a Part Time classification.

      Part Time Employees whose contributions begin with their 31st week of employment and continue for eight weeks become eligible for the first Eligibility Week, following their 38th week of employment, for which the Fund receives a contribution. Part Time Employees whose contributions begin 90 days after the completion of 1200 hours of employment in a Part Time classification become eligible for the first Eligibility Week for which the Fund receives a contribution.

   c. Employees covered by a Contributing Employer's Company Plan, or a different multi-employer plan a Contributing Employer is required to make contributions to, may become Part Time or Full Time Employees, as defined herein. Such Employees become eligible for the first Eligibility Week for which the Contributing Employer makes a contribution on their behalf.

4. **Continuing Eligibility Maintenance**.

   a. Once Initial Eligibility is established, benefit eligibility for Full Time Employees and Part Time Employees will continue for each Eligibility Week for which the Contributing Employer makes a contribution to the Fund. Contributions are due for each week the Employee was paid Compensable Time, and may be due in some circumstances under the Family Medical Leave Act or other applicable law.

   b. Depending on the Collective Bargaining Agreement, Contributing Employer contributions may also be made for individuals on Short Term Disability, or receiving workers compensation payments, for those time periods specified by the Collective Bargaining Agreements, and such contributions will generate benefit eligibility for each Eligibility Week for which they are made. (Note: some Collective Bargaining agreements provide continued employer contribution coverage for you and your dependents for up to 52 weeks if you are receiving a Long Term Disability benefit.)

   c. For individuals eligible for and receiving the Short Term Disability benefits provided by this Fund to weekly-eligible employees, additional benefit eligibility for benefits other than Short Term Disability benefits will be extended by the Fund during the period of disability, ending with the end of the last Eligibility Week for which Short Term Disability benefits are payable. In no event will such eligibility extend beyond 26 weeks from the onset of the disability for which Short Term Disability benefits are payable. See the Article on Short Term Disability in this document.

   d. Generally, your coverage ends when your employer is not required, or is no longer making, weekly health contributions on your behalf. You do not have coverage during any week for which your employer is not obligated to make contributions (for example, if you are on layoff or you quit employment). Your coverage may continue after employer contributions end if you choose to make self-payments as explained in the COBRA ("Self-Payments") section of this Article. If employer contributions end due to the death of an employee, family members may be eligible for extended medical coverage as explained in this Article under "Continuing Dependent Eligibility under the Family Protection Benefit."

5. **Dependent Eligibility Establishment and Maintenance**.

   A dependent is any of the following individuals: Dependent Child(ren) or Spouse as those terms are defined in the Definitions Article of this document. Dependent benefit eligibility is co-extensive with Employee eligibility if the Dependent is properly enrolled in the Plan.

   All existing Dependents of an Eligible Employee must be enrolled within **90 days** of the Employee's initial eligibility or, if applicable, reinstatement of eligibility, in order for the Dependent to gain eligibility as of the date of the Employee's eligibility. If an existing Dependent is not properly enrolled in this 90-day period, then eligibility for that Dependent will begin on the first day of the week following their proper enrollment.

   Dependent Enrollment Process: Dependents are considered properly enrolled upon the Employee's completion of an enrollment form and the submission of the information required under the Proof of Dependent Status Provision below.

   a. **Special Rule for Newly-Acquired Spouse and Step-children:** A newly acquired spouse of an Eligible Employee will be covered as of the date of the marriage to the Employee, if properly enrolled within 90 days of the marriage. The newly acquired eligible stepchildren may also be enrolled. Individuals will be requested to complete an enrollment form and provide proof and identification data for the Dependent Spouse (if requested). If a newly acquired Spouse is not properly enrolled within this 90-day period, then eligibility for that Dependent will begin on the first day of the week following their proper enrollment.

   b. **Special Rule for Newborns:** Newborn Dependent Children of an Eligible Employee will automatically be covered for the first 31 days after the date of birth. Thereafter, for continued coverage, you must properly enroll the newborn within 90 days of their birth. Individuals will be requested to complete an enrollment form and provide proof and identification data for the Dependent (if requested). If a newborn Dependent child is not properly enrolled within this 90-day period, then eligibility for that Dependent will end after 31 days and begin again on the first day of the week following their proper enrollment.

   c. **Special Rule for Adopted Children**: Adopted Children, or children "Placed for Adoption" with an Eligible Employee will be covered from the date of adoption, or the date of placement for adoption, if earlier, if properly enrolled within 90 days of the adoption or placement for adoption. A child is "Placed for Adoption" on the date a Covered Employee first become legally obligated to provide full or partial support of the child for whom adoption is planned. Individuals will be requested to complete an enrollment form and provide proof and identification data for the Dependent (if requested). If an adopted child is not properly enrolled within this 90-day period, then eligibility for that Dependent will begin on the first day of the week following their proper enrollment. If a child is Placed for Adoption and is properly enrolled, and if the adoption does not become final, coverage of that child will terminate as of the date the Covered Employee no longer has a legal obligation to support that child.

      Individuals enrolled during Special Rule Enrollment periods (noted above) have the Plan benefits and the same enrollment requirements as are available to similarly-situated employees at Initial eligibility enrollment.

d. **Proof of Dependent Status**: Specific documentation to substantiate Dependent status will be required by the Plan and may include proof that the dependent is related to the employee and Social Security Number or Tax Identification Number of the dependent(s) posed for addition to the plan, other documents deemed necessary by the Plan, and any of the following:

1) **Marriage:** copy of the certified marriage certificate.
2) **Birth:** copy of the certified birth certificate.
3) **Adoption or placement for adoption:** court order of a court of competent jurisdiction signed by the judge.
4) **Permanent Guardianship:** a copy of the decree, letters or court order of a court of competent jurisdiction implementing the permanent guardianship.
5) **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document or National Medical Support Notice.
6) **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally retarded or mentally or physically disabled (as that term disabled is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on the Covered Employee and/or Spouse for support and maintenance. The plan my require proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

e. **When both spouses are Eligible Employees** their children are eligible as Dependents only of that Eligible Employee selected for that purpose. Further, no Eligible Employee can be covered as a Dependent Spouse of another Eligible Employee. **No Eligible Employee can be covered both as a Dependent Child and as an Eligible Employee.**

Important Note: You or your Dependents **must promptly furnish to the Administrative Office** information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan preferably within 31 days, but no later than 90 days, after any of the above noted events. However, if notice of a COBRA qualifying event is not received by the Administrative Office within the required **60-day** period (as discussed in the COBRA section below, in this Article 3), the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Failure to give the Administrative Office a timely notice of the above noted events may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and vision plan benefits.

It is extremely important that you notify the Administrative Office should you get divorced.

f. **Medicaid Or A State Children's Health Insurance Program (CHIP).**

When you are eligible for benefits under this Plan, you and your dependents **may also enroll in this Plan** if you (or your eligible dependents):

1) have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **90 days** after the Medicaid or CHIP coverage ends. Note that if the individual requests enrollment **within 90 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** generally coverage will become effective on the first day of the week following the date of the event that allowed this Special Enrollment opportunity; or

2) become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **90 days** after you (or your dependents) are determined to be eligible for such premium assistance.

6. **Weekly Eligibility – Termination**

a. **Employee.** The benefit eligibility of Full Time and Part Time Employees terminates at the end of the last Eligibility Week for which a contribution was made by the Contributing Employer, unless extended pursuant to any Fund benefit extension described in this section.

b. **Dependents.** Dependent benefit eligibility terminates when the Covered Employee's eligibility terminates, or if earlier, when the Dependent no longer meets the definition of a Dependent or the Dependent spouse enters the military service of any country.

The eligibility of an Employee or Dependent will terminate on the date on which the benefits provided herein are terminated by the Board of Trustees.

When The Plan Can End Your Coverage For Cause: In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums and self-payments are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact.

7. **Weekly Eligibility – Reinstatement**. A Full Time or Part Time Employee's benefit eligibility may be reinstated upon the submission of a weekly contribution by the Contributing Employer.

This means that if you lose coverage after having been an active participant and return to work while retaining seniority status with a contributing employer, you do not need to reestablish eligibility. Your eligibility will be effective for the Eligibility Week for which the contribution is received by the Fund, meaning that your coverage will begin with your first Employer Contribution. If you do not return to work while retaining seniority status with your employer, you must reestablish eligibility as a newly hired employee.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA).

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the week in which the employee stopped working.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage.

Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Administrative Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If the employee goes into active military service for up to **31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave. If contributions for coverage are not required of an active employee before a USERRA leave, then an employee going on military leave cannot be required to make contributions for coverage during the first 31 days of a USERRA leave.
- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the last day of the week in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA section of this Article for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years. The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Family Medical Leave Act (FMLA).

A Regular Employee eligible for leave under the Family Medical Leave Act who takes such leave from covered employment shall be covered as if actively employed. The Contributing Employer owes a Contribution for the leave period if the Regular Employee would have had a Contribution made on his or her behalf but for the FMLA leave. Eligibility under FMLA must be exhausted prior to the implementation of any disability extension or any other approved leave of absence. The Contributing Employer is responsible for notifying the Fund's Administrative Office of Regular Employees who are eligible for FMLA.

Self-Payment and COBRA Continuation of Coverage.

Self-Payment Rights for Weekly-Eligible Employees/ Dependents will be on a weekly basis.

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible employees and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary

continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace** (the Marketplace helps people without health coverage find and enroll in a health plan).

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this Article is intended to expand a person's COBRA rights.

COBRA Administrator: The COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is the Administrative Office The contact information for the Administrative Office is shown in the Quick Reference Chart in the front of this document.

IMPORTANT

This Article serves as a notice to summarize your rights and obligations under the COBRA Continuation Coverage law. It is provided to all covered employees and their covered Spouses and is intended to inform them (and their covered dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this Article carefully and be familiar with its contents.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

1. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
   - A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice, during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
   - A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.
2. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminates (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

[1] *When a covered employee's Qualifying Event (e.g,. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*

Special Enrollment Rights

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this Article. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the **date of the loss of Plan coverage (generally the end of the week, or as applicable the end of the month, in which the Qualifying Event occurred)**. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this Article on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this Article.

Medicare Entitlement

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law. Generally a person becomes entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to these events: a divorce or legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

That written notice should be sent to the Administrative Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Administrative Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Officials of the employee's own employer should notify the Administrative Office within 30 days of these events: an employee's death, termination of employment including retirement, reduction in hours making the employee ineligible for coverage, or entitlement to Medicare (if it causes the employee to be ineligible for coverage). However, **you or your family should also promptly notify the** Administrative Office **in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the Administrative Office** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the Administrative Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.** Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this Article for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the employer's Fund's and employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

NOTE: You may not receive an invoice (bill) for the initial COBRA premium payment or for the weekly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage to the COBRA Administrator listed on the Quick Reference Chart.

IMPORTANT

There will be no invoices or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.

Grace Periods

The **initial payment** for the COBRA Continuation Coverage is due to the Administrative Office **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After the initial COBRA payment, **subsequent payments** are due on the first day of each week, but there will be **a 30-day grace period** to make those payments. If payments are not made within the 30-day time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

What If The Full COBRA Premium Payment Is Not Made When Due?

If the Administrative Office receives a COBRA premium payment that is not for the full amount due, Administrative Office will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall then COBRA continuation coverage will end on the last day full COBRA premium was made. If there is not a significant shortfall, the Administrative Office will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the week in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee) are enrolled for COBRA Continuation Coverage, you have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage if you do so within 31 days after the birth, adoption, or placement for adoption. The child will be entitled to the full duration of COBRA.

If you marry while you are enrolled for COBRA, your spouse is not a Qualified Beneficiary, but the spouse can be added for the remainder of the duration of your existing COBRA coverage.

Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee) are enrolled for COBRA Continuation Coverage your Spouse or dependent loses coverage under another group health plan, you may enroll the Spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or dependent within 31 days after the termination of the other coverage.

Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Administrative Office an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare (Part A, Part B or both), or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to 36 months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and dependents who are Qualified Beneficiaries.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the Administrative Office in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:
   - the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
   - the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

   Notifying the Plan: you or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the Administrative Office of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the Administrative Office before the end of the 18-month COBRA Continuation period.
2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.
3. The Administrative Office must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the premium payment amount due for COBRA coverage is **not paid in full and on time**;
2. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
3. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the last day of the week in which the Qualified Beneficiary is covered under the other group health plan.
4. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).
6. The date the Fund no longer provides group health coverage.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Administrative Office determines that COBRA coverage will terminate early. Once COBRA coverage terminates early it cannot be reinstated.

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

Appealing an Adverse Determination Related to COBRA

If an individual receives an adverse determination (denial) related to a request for eligibility for COBRA (such as with a Notice of Unavailability of COBRA), a request for extension of COBRA for a disability, a request for extension of COBRA for a second qualifying event, or a notice of early termination of COBRA, the individual is permitted to appeal to the Plan. To request an appeal, follow this process:

1. Send a written request for an appeal to the Administrative Office within 60 days of the date you received the adverse determination letter.
2. Explain why you disagree with the adverse determination.
3. Provide any additional information you want considered during the appeal process.
4. Include the most current name and address of each individual affected by the adverse determination.

The Administrative Office will respond in writing to this appeal within 90 days of the Plan's receipt of the request for appeal. The appeal response will be sent to the address provided by the individual. This concludes the COBRA appeal process.

Note that a claim for reimbursement of health expenses would follow the claim appeal processes outlined in the Claim Filing and Appeals Information Article of this document.

COBRA Questions or To Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact the Administrative Office, whose address is listed on the Quick Reference Chart in the front of this document.

For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the Administrative Office:

1. within 31 days of a **change in marital status (e.g. marry, divorce)**; or have **a new dependent child**; or
2. within 60 days of the date you or a covered dependent Spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered child **ceases to be a "dependent child"** as that term is defined by the Plan; or
4. promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

Continuing Dependent Eligibility under the Family Protection Benefit.

Under the terms of your Plan, all of your family's health care benefits will come to an end when you, the employee, die unless your Dependent(s) choose to continue benefits under this Plan by:

1. making self-payments for COBRA continuation coverage or,
2. when you are eligible, electing to continue coverage under the Plan's no cost Family Protection Benefit, discussed below.

Note that if COBRA is elected instead of the Family Protection Benefit, the Family Protection Benefit is not available to be elected after COBRA coverage has ended. If the Family Protection Benefit is elected, then COBRA continuation coverage is not available to be elected after the Family Protection Benefits has ended.

If at the time of the employee's death the employee was eligible for retiree coverage, the dependents will be required to continue coverage under the retiree plan and not under this Family Protection Benefit.

Eligibility for the Family Protection Benefit

If, during the two years prior to your death, you and your covered dependents used in-network providers exclusively for all non-emergency medical care, your covered spouse, and covered dependent children will be eligible for **up to five years of continued health coverage at no cost**. If qualified, your spouse, and children will remain covered under the same plan of benefits as you were prior to your death, **but only for care provided by participating in-network doctors and hospitals (unless there is an emergency out-of-network).**

If the Covered Employee and their Dependents used an out-of-network provider through no fault of their own and the claim was paid at the In-Network level of benefits, the Covered Individuals will not be disqualified.

To apply for the Family Protection Benefit, contact the Administrative Office. You will be asked to complete an application form (available from the Fund's website) and provide it to the Administrative Office. It is the responsibility of the qualifying dependent to notify the Administrative Office when their address changes, or they have a terminating event as explained in this section.

Benefit Provision under the Family Protection Benefit

When qualified for the Family Protection Benefit, Dependents will remain covered under the same plan of medical, dental and vision benefits, **but only for care provided by participating In-Network doctors, dentists, hospitals and other covered health care providers, unless there is an emergency out-of-network.**

Duration of Coverage under the Family Protection Benefit

Your spouse will receive benefits for a **maximum of five years** or until eligible for other insurance (including Medicare) or until remarriage, whichever occurs first. In addition, each of your children will receive benefits for a **maximum of five years** or to the date the Dependent Child no longer meets the Plan's definition of Dependent Child, whichever occurs first. Even if your spouse remarries, the Plan will continue to cover your children unless they have a terminating event (noted below).

Coverage under this Family Protection Benefit provision will be in lieu of any self-payment coverage extension that might otherwise have been available hereunder, such as COBRA continuation coverage.

In the event of the birth of a child to a surviving spouse covered under this benefit, the newborn will automatically be covered for the first 31 days after birth. To continue the child's coverage beyond this timeframe the newborn must be properly enrolled. See the Dependent Enrollment Process explained earlier in this Article. Note that the Plan does not consider a child of a Dependent Child to be an eligible Dependent under this Plan.

Events Causing Termination of the Family Protection Benefit

A Dependent Spouse will be eligible for this benefit until the earlier of:

a) a maximum of five (5) years;

b) the date the Spouse becomes eligible for other insurance (including, but not limited to Medicare and any retired employee benefit coverage available under this Fund);

c) the date the Dependent Spouse remarries;

d) the date on which the benefits provided herein are terminated by the Board of Trustees.

Dependent Children will be eligible for this benefit until the earlier of:

a) a maximum of five (5) years;

b) the end of the month in which the children reach age 26;

c) the date on which the benefits provided herein are terminated by the Board of Trustees.

ARTICLE 4: PRECERTIFICATION AND UTILIZATION MANAGEMENT (UM)

Purpose of the Utilization Management (UM) Program: Your plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new drugs, medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the Fund to afford the cost of maintaining your plan.

To enable your plan to provide coverage in a cost-effective way, your plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Management Program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, your plan provides reduced benefits, and you'll be responsible for paying more out of your own pocket.

Management of the Utilization Management Program: The Plan's Utilization Management Program is administered by various independent professional Utilization Management Companies operating under a contract with the Plan (hereafter referred to as the UM Company). Certain outpatient drugs require precertification as managed by the Prescription Drug Program. The contact information for the UM Companies and Prescription Drug Program appears in the Quick Reference Chart in the front of this document.

For the Medical PPO Plan, the health care professionals in the UM Company focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan. For the Dental PPO Plan, the dental care professionals in the Dental Plan Claims Administration office focus their review on the necessity, appropriateness and cost-effectiveness of proposed dental services.

Elements of the Utilization Management Program: The Plan's Utilization Management Program consists of:

1. **Precertification (preservice) review**: review of proposed health care services before the services are provided;
2. **Concurrent (continued stay) review**: ongoing assessment of the health care as it is being provided, typically involving inpatient confinement in a hospital or health care facility or review of the continued duration of healthcare services;
3. **Retrospective review**: review of health care services after they have been provided; and
4. **Case Management**: a process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the Fund work together under the guidance of the Plan's independent Utilization Management Company to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

Restrictions and Limitations of the Utilization Management Program (Very Important Information):

1. The fact that your Physician recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Medical Plan.
2. The Utilization Management Program is not intended to diagnose or treat medical or dental conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your Physician (or Dentist or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or Dentist or other Health Care Provider) believes to be the most appropriate, even if the UM Company does not certify proposed surgery/treatment/service or admission as Medically Necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the UM Company.
4. With respect to the administration of this Plan, the Fund, the Claims Administrators and the UM Companies are not engaged in the practice of medicine or practice of dentistry, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as Medically Necessary, or for the results if the patient chooses not to receive health care or dental care services that have not been certified by the UM Company as Medically Necessary.

5. **Precertification of a service does not guarantee that the Plan will pay benefits for that service** because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during precertification varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

APPROPRIATE UTILIZATION MANAGEMENT (UM) COMPANY

Appropriate Utilization Management Company means the companies/organizations and types of services outlined in the chart below. (See the Quick Reference Chart in this document for the contact information for these Appropriate Utilization Management Companies)

Appropriate Utilization Management (UM) Company	Types of Services to be Precertified (Pre-approved)	Where to Find Information on Precertification of the Service
Medical Plan Claims Administrator	Certain medical plan services obtained from an out-of-network provider	In the precertification section of this Article
Prescription Drug Program	Certain outpatient drugs including specialty drugs	In the Drug row of the Schedule of Medical Benefits
Dental Plan Claims Administrator	Certain dental services such as dental implants	In the Dental PPO Plan Article

PRECERTIFICATION (PRESERVICE) REVIEW

How Precertification Review Works:

Precertification Review is a procedure, administered by the appropriate UM Company, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary. Precertification review for dental services assures that the dental service meets or exceeds acceptable standard of dental care.

- **If you are using an in-network medical plan provider,** that provider will perform the precertification duties for you.
- **If you are using an out-of-network medical plan provider, YOU must perform the precertification** duties in order to avoid a financial penalty. This means that you must precertify (obtain pre-approval) BEFORE the following services are provided:

THE SERVICES TO BE PREAPPROVED (PRECERTIFIED) BY CONTACTING THE APPROPRIATE UTILIZATION MANAGEMENT COMPANY:

The following medical plan services must be precertified by contacting the Medical Plan Claims Administrator:

1. Stays in (admission to) a **hospital**.
   (*Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section*);
2. Stays in (admission to) a **Skilled Nursing Facility (SNF),** or Subacute facility/Long Term Acute Care facility.
3. Stays in (admission to) a **Rehabilitation facility**.
4. Stays in (admission to) a **residential treatment facility** for treatment of mental disorders, alcoholism or drug abuse treatment.
5. **Home health care**.
6. **Private Duty nursing care**.
7. Administration of a **class of drugs called "survival motor neuron-2 (SMN2)-directed antisense oligonucleotides,"** which includes drugs such as Spinraza (nusinersen).
8. Infertility Services.

Certain outpatient prescription drugs must be precertified by contacting the Prescription Drug Program.

See the Drug row of the Schedule of Medical Benefits for more information or contact the Prescription Drug Program (contact information listed on the Quick Reference Chart in the front of this document).

Certain Dental PPO Plan benefits, such as dental implants, must be precertified by contacting the Dental Plan Claims Administrator.

See the Dental PPO Plan Article 8 and the contact information for the Dental Plan Claims Administrator in the Quick Reference Chart in the front of this document).

THE SERVICES TO BE PREAPPROVED (PRECERTIFIED) BY CONTACTING THE APPROPRIATE UTILIZATION MANAGEMENT COMPANY:

Precertification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.

How to Request Precertification (Pre-service Review):

REMINDER:

It is YOUR RESPONSIBILITY to assure that precertification occurs when it is required by this Plan. Any penalty for failure to precertify is on you, not the Health Care Provider.

For services that require precertification (pre-approval), you or your Physician must call the appropriate UM Company at their telephone number shown in the Quick Reference Chart in the front of this document.

1. **Calls for elective services should be made at least 14 days before the expected date of service.**
2. The caller should be prepared to provide all of the following information: the Fund's name, employee's name, patient's name, address, and phone number and social security number; Physician's name, phone number or address; the name of any Hospital or facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services.
3. When calling to precertify, **if the preservice review process was not properly followed** the caller will be notified as soon as possible but no later than 5 calendar days after your request.
4. If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, and will let you, your Physician and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. The UM Company will usually respond to your treating Physician or other Health Care Provider **by telephone within 3 working days (but no later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
5. **Note that an approved precertification does not guarantee payment of benefits. This could be for a variety of reasons such as: the information submitted during precertification varies from the actual services performed on the date of service, the service performed is not a covered benefit, and/or you are ineligible for benefits on the actual date of service**. Precertified services performed by an Out-of-Network provider are still reimbursed up to the Allowed Amount and you may be subject to balance billing.
6. If your admission or service is determined not to be Medically Necessary, you and your Physician will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Appeal Information Article regarding appealing a UM determination.
7. If you do not receive the approved/precertified service within 60 days of the certification, or if the nature of the service changes, a new precertification must be obtained.

EMERGENCY HOSPITALIZATION

If an emergency requires hospitalization, there may be no time to contact the appropriate UM Company before you are admitted. If this happens, **the UM Company must be notified of the hospital admission within 48 hours**. You, your Physician, the hospital, a family member or friend can make that phone call to the UM Company. This will enable the UM Company to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Physician or other Health Care Providers of the various In-Network support providers and benefits available for you and offer recommendations, options and alternatives for your continued medical care.

If the call cannot be made within 48 hours it must be made as soon as possible. If your hospital admission begins on a Friday or Saturday, the call must be made to the appropriate UM Company within 72 hours of that admission.

CONCURRENT (CONTINUED STAY) REVIEW

How concurrent (continued stay) review works:

1. When you are receiving medical services in a hospital or other inpatient health care facility, the appropriate UM Company will monitor your stay by contacting your Physician or other Health Care Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.
2. Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Physician or other Health Care Providers of various options and alternatives for your medical care available under this Plan.
3. If at any point your stay or services are found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Physician will be notified. This does not mean that you must leave the hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay or services were not Medically Necessary, no benefits will be paid on any related hospital, medical or surgical expense.

PREGNANCIES

Pregnant women should notify the UM Company as soon as possible once they know they are pregnant. This helps to assure that the pregnant woman will receive adequate prenatal care, allow for planning for the upcoming delivery, and enable the Plan to provide adequate educational material regarding pregnancy. It also enables the UM Company to work with the treating Physician to monitor for high risk pregnancy factors and to assist the pregnant woman in completing the steps to assure that plan benefits will be available for the newborn child.

RETROSPECTIVE (POST-SERVICE) REVIEW

Claims for medical services or supplies that have not been reviewed under the Plan's Precertification, Concurrent (Continued Stay) Review, or Second and Third Opinion Programs may, at the option of the Claims Administrator, be subject to retrospective review to determine if they are Medically Necessary. If the Claims Administrator receives a determination from a UM Company or other designated medical review firm that services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies.** See also the section of this Article regarding Appealing a UM Determination. For complete information on claim review and claim appeals, see the Claim Filing and Appeals Information Article of this document.

CASE MANAGEMENT

How Case Management Works: Case Management is a voluntary process, administered by the UM Company. Its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the Fund to coordinate a timely and cost-effective treatment program.

Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers. See the section titled Restrictions and Limitations of the Utilization Management Program in this Article.

Working with the Case Manager: Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling the UM Company at the telephone number shown on the Quick Reference Chart in the front of this document. However, in most cases, the UM Company will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Physician, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Non-Network Health Care Providers as needed. From time to time, the Case Manager may confer with your Physician or other Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Physician may call the Case Manager of the Utilization Management Company at any time at the telephone number shown on the Quick Reference Chart in the front of this document to ask questions, make suggestions, or offer information.

APPEALING A UM DETERMINATION (APPEALS PROCESS)

You may request an appeal of any adverse review decision made during the precertification, concurrent review, retrospective review, Case Management described in this Article. To appeal a denied claim/bill, see the Claim Filing and Appeal Information Article of this document.

FAILURE TO FOLLOW REQUIRED UTILIZATION MANAGEMENT PROCEDURES (VERY IMPORTANT INFORMATION)

For failure to precertify the required procedures, the Plan applies a **penalty of $250** per occurrence.

A penalty for failure to follow the Plan's precertification procedures will not accumulate to meet an annual Out-of-Pocket Limit. See also the Claim Filing and Appeals Information Article of this document.

ARTICLE 5: MEDICAL PPO PLAN BENEFITS

The medical PPO plan(s) provided under the Teamsters Western Region and Local 177 Health Care Plan is described in this Article.

In specified geographic areas of the U.S., the Fund may offer Eligible Employees (and to their Eligible Dependents) the option to elect the Medical HMO Plan. The Medical HMO Plan is not described in this document. Contact the Administrative Office for information about the Medical HMO Plan option. Additionally, the Fund has contracted with various PPO networks in order to assure that members have access to a comprehensive group of health care providers. The Quick Reference Chart, at the front of this document, shows the name and contact information for the various PPO networks.

Eligible Medical Expenses (Covered Charges).

1. Under the Medical PPO Plan you are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expense." Eligible medical expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

   a. determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that the charges are **"Allowed Charges"** (as those terms are defined in the Definitions Article of this document). The fact that a physician prescribes or orders the service does not, in itself, make it medically necessary or a covered expense; and

   b. not services or supplies that are **excluded from coverage** (as provided in the Medical PPO Plan Exclusions Article of this document); and

   c. not services or supplies **in excess of a Maximum Plan Benefit** shown in the applicable Schedule of Medical Benefits, and

   d. for the **diagnosis or treatment of an injury or illness** (except where certain wellness/preventive services are payable by the Plan as noted in the applicable Schedule of Medical Benefits in this document); and

   e. **expenses incurred while you are covered under this Plan**. An expense is incurred on the date you receive the service or supply for which the charge is made.

2. Generally, **the Plan will not reimburse all Eligible Medical Expenses**. Covered Individuals will have to pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once a maximum out-of-pocket cost has been incurred in each calendar year, for providers used In-network and Out-of-Area, no further cost-sharing will be applied for that calendar year (see Out-of-Pocket Limit for more details).

Non-Eligible Medical Expenses.

The Plan will not reimburse any expenses that are not Eligible Medical Expenses. That means Covered Individuals are responsible for paying the full cost of all expenses that are determined to be medically unnecessary, determined to be in excess of the Allowed Charges, not covered by the Plan, in excess of a Maximum Plan Benefit or not payable on account of failure to comply with the Plan's Precertification requirements as described in Article 6 in this document.

In-Network, and Non-Network Health Care Provider Services / Out-of-Area.

Plan Participants may obtain health care services from In-Network or Out-of-Network Health Care Providers. But the amount that you pay for such services may vary.

In-Network Services: In-Network Health Care Providers have agreements with the Plan's Preferred Provider Organization under which they provide health care services and supplies for a favorable negotiated discount fee for plan participants. When a plan participant uses the services of an In-Network Health Care Provider, the Plan participant is responsible for paying the applicable cost-sharing (coinsurance on the discounted fees) for any Medically Necessary services or supplies, subject to the Plan's limitations and exclusions. **Your lowest out-of-pocket costs occur when you use an in-network provider**

1. **In-Network (also called Participating, Contracted, Network and PPO):** In-Network refers to health care providers who are contracted with the PPO Network and who are located within the geographic service area of the PPO Network. The Plan will notify you of your PPO Network.

   If you receive medical services or supplies from a Health Care Provider that is contracted with the Plan's medical network **you will be responsible for paying less money out of your pocket**. Also, In-Network Health Care Providers generally submit their claims directly to the Plan instead of to you.

Health Care Providers who are under a contract with the PPO Network have agreed to accept the allowed amount the Plan pays for covered services, plus any additional copayments or coinsurance for which the Covered Individual is responsible, as payment in full, except with respect to certain claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance. In those cases, the contracts of Health Care Providers with the PPO do not require them to adhere to the discounted amount the Plan pays for covered services, and they may charge in excess of what this Plan considers an Allowed Charge.

You must present your PPO Identification Card (ID card) when you or Eligible Dependents visit a PPO provider in order to obtain the discounted fees. PPO providers are listed in the Provider Directory available at no cost on the PPO network website or from the Administrative Office (see the Quick Reference Chart in the front of this document for contact information). These preferred providers and their discounts can change as the agreements are re-negotiated by the PPOs.

Because Health Care Providers are added to and deleted from networks during the year you should call the network or ask the provider to verify their contracted network status before you visit that provider to assure you will be able to receive their discounted price for the services you need.

You may verify if your Health Care Provider is an In-Network provider by viewing the online Provider directory on the Medical Plan PPO network website or by contacting the Medical Plan PPO Network at their phone number and website listed on the Quick Reference Chart in the front of this document.

If you choose not to use PPO providers, your identification card can still be used to identify the Plan to your provider for verification of regular Plan benefits and where to submit claims, subject to the normal eligibility rules.

Show your ID card to the health care provider every time you use services so they know that you are enrolled under this Plan and where to send their bills.

2. **Out-of-Network (also called Non-Network, Non-PPO, Non-Contracted or Non-Participating):** Out-of-Network refers to providers who are **not contracted** with the PPO Network to provide the discount other Network providers offer to the participant or to the Plan. Out-of-Network providers often send their full bill to you instead of the Plan.

   Out-of-Network Health Care Providers **often bill a Covered Individual for any balance that may be due in addition to** the allowed amount payable by the Plan, also called balance billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than normal cost-sharing like copayments or coinsurance) that exceed the Plan's payment for a covered service. **To avoid balance billing, use in-network providers**. It generally costs you more money out of your own pocket if you use out-of-network providers, except emergency services provided in an emergency room.

3. **Out-of-Area:** Out-of-Area refers to covered individuals who reside outside the PPO plan's service area. Out-of-Area providers are Out-of-Network providers who are **not contracted** with the PPO Network and who are located outside the **service area** of the PPO Network. These Out-of-Network Health Care Providers **may bill a Covered Individual for any balance that may be due in addition to** the allowed amount payable by the Plan, also called balance billing.

   Under this Medical PPO Plan, if a covered individual resides outside the PPO Plan's service area, covered services obtained from the Out-of-Network provider will be processed at the in-network level of benefits.

4. **Service Area**: A **"Service Area"** is a geographic area serviced by the In-Network Health Care Providers who have agreements with the Plan's network(s). If you and/or your covered Dependent(s) **reside (live) more than 91 miles** from the nearest In-Network Health Care Provider whose services or supplies are determined by the Plan Administrator or its designee to be medically necessary covered services for the condition being treated, the Plan will consider that you live outside the Service Area. In that case, your claim for services or supplies by an Out-of-Network Health Care Provider will be treated as if the services or supplies were provided In-Network.

5. **Health Maintenance Organization Option (HMO):** Covered individuals in certain geographic areas (California and Hawaii, currently) will have the option to select an HMO in lieu of PPO medical plan coverage. If you select coverage through the HMO all of your medical care (including outpatient prescription drug benefits) is provided by HMO providers and facilities (except in emergency situations). In some HMOs, you select a Primary Care Physician to coordinate most of your care. Your medical, mental health, vision and prescription benefits will be provided by the HMO organization. However, dental and vision benefits are provided as described in this document. Those individuals selecting the HMO Medical Plan will automatically receive further information regarding coverage. Individuals can request more details from the Administrative office. The contact information for the HMO Medical plan is listed on the Quick Reference Chart in the front of this document.

Before you obtain services or supplies from an Out-of-Network Health Care Provider, you can find out whether the Plan will provide In-Network or Out-of-Network Benefits for those services or supplies by contacting the Medical Plan PPO Network at their phone number and/or website shown on the Quick Reference Chart in the front of this document.

IMPORTANT NOTE

Because providers are added to and dropped from the Network periodically throughout the year it is best if you ask your Health Care Provider IF they are still participating with the Network, or contact the Network each time BEFORE you seek services.

For a list of In-Network providers, see the website of the Network located on the *Quick Reference Chart* in the front of this document.

For a paper copy of the provider directory, at no charge, contact the In-Network Providers for the Medical PPO Plan as listed on the Quick Reference Chart in the front of this document.

6. Special Reimbursement Provisions: The following chart explains the Plan's special reimbursement for services when certain Out-of-Network providers are used. The Plan Administrator or its designee determines if and when the following special reimbursement circumstances apply to a claim after the normal claim adjudication processes have been followed/investigated. Medical records may be requested in order to assist with a determination on the need for a special reimbursement provision. Allowed charge is defined in the Definitions Article of this document.

SPECIAL REIMBURSEMENT PROVISIONS This chart explains the Plan's special reimbursement provisions if the services of certain Out-of-Network Providers are used. The Plan Administrator or its designee determines if/when the following reimbursement applies to a claim.	**WHAT THE PLAN PAYS (toward eligible claims submitted by an Out-of-Network provider)**
a) The non-grandfathered medical plan does not have an in-network provider qualified or available to provide the preventive services required by the Affordable Care Act so the participant must use the services of a non-network provider and claims will be reimbursed without any participant cost-sharing, in the same manner as if an in-network provider had been used. b) The individual had care for a medical emergency (as emergency is defined in this Plan) at a provider outside the In-Network service area. c) The individual was treated/confined in an In-Network facility but an Out-of-Network provider (outside the patient's control) performed certain Medically Necessary covered services such as emergency room visit, pathology, laboratory, radiology, anesthesia, or assistant surgeon services. d) Ancillary services (such as lab or x-rays) received from an Out-of-Network provider in connection with a visit to an In-Network provider, if the choice of the Out-of-Network provider who performed ancillary services was outside the patient's control. For example, the In-Network provider accidentally sends the patient's lab work to an Out-of-Network lab for processing. e) Within the network service area there is no In-Network provider qualified by area of professional specialty or practice available to provide Medically Necessary eligible health care services. f) Within the network service area the individual was treated by an Out-of-Network facility/professional because of the lack of availability of an In-Network facility/professional.	As if the care was provided In-Network (including any applicable cost-sharing like coinsurance, copays and Out-of-Pocket Limit) and the allowance for bills will be reimbursed according to the billed charge for Out-of-Network providers. The Plan reserves the right to have the billed amount of a claim negotiated for a discount and/or reviewed by an independent medical review firm/provider to assist in determining if the charges are medically necessary and/or for a medical emergency. See the definition of Allowed Charge in the Definitions Article of this Plan.
g) Use of an Out-of-Network provider when an In-Network provider was available to be used.	As if the care was provided Out-of-Network (including any applicable cost-sharing like coinsurance, copays and Out-of-Pocket Limit). The Plan reserves the right to have the billed amount of a claim negotiated for a discount and/or reviewed by an independent medical review firm/provider to assist in determining if the charges are medically necessary and/or for a medical emergency.

Precertification.

Precertification may be required for a variety of medical plan services, and for certain classes of drugs under the Prescription Drug Program. Precertification requirements are discussed in Utilization Management Article 4.

Deductibles.

1. A Deductible is the amount of expenses you incur for covered medical expenses each calendar year before covered medical expenses are payable by the Plan. Each calendar year, Covered Individuals (and **not** the Plan) are responsible for paying all Eligible Medical Expenses until the annual Deductible is satisfied, and then the Plan begins to pay benefits.
2. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. The amount applied to the Deductible is the "Allowed Charge" amount as defined in the Definitions Article of this document.
3. Deductibles under this Plan are accumulated on a Calendar Year basis.
4. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles. A penalty for failure to obtain precertification for services does not accumulate to meet a Deductible. Copayments are also not applied to meet the Deductible.
5. There are two types of Deductibles: Individual and Family.
   - The **Individual Deductible** is the maximum amount one covered person has to pay toward Eligible Medical Expenses before Plan benefits begin for that covered person. The Plan's Individual Deductible is described in the Schedule of Medical Benefits.
   - The **Family Deductible** is the maximum amount that a family of two or more persons (a covered person with one or more dependents) has to pay in total toward Eligible Medical Expenses before Plan benefits begin for anyone in the family (covered person or dependent) who has not already met the Individual Deductible. The Plan's Family Deductible is described in the Schedule of Medical Benefits.
6. There is no Deductible applied to Medical PPO Plan benefits.
7. **Expenses Not Subject to Deductibles**: Certain Eligible Medical Expenses are not subject to Deductibles like preventive/wellness type services. These expenses may be covered 100% by the Plan, or they may be subject to Copayments (explained below).*

   *NOTE: COVID-19 testing, diagnosis and treatment will not be subject to the Deductible beginning on March 1, 2020 through the end of the Emergency Period during which the federal government has announced a National Emergency.
8. The Schedule of Medical Benefits in this document will specify when Eligible Medical Expenses are not subject to Deductibles.

Coinsurance.

1. Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. The Plan generally pays a percentage of the Eligible Medical Expenses, and the Covered Individual (and **not** the Plan) is responsible for paying the rest. The part you pay is called the Coinsurance. The coinsurance related to a covered medical expense is described on the Schedule of Medical Benefits.

   If the services of an In-network Health Care Provider are used, you will be responsible for paying less coinsurance and therefore, less money out of your pocket.

Copayment.

1. A copayment (or copay, as it is sometimes called) is a set dollar amount the Covered Individual (and **not** the Plan) is responsible for paying when Eligible Medical Expense is incurred. The Plan's copayments are indicated in the Schedule of Medical Benefits. For example, there is a copay for in-network provider office visits under the Medical PPO Plan.
2. Copayments **do accumulate** to the annual Out-of-Pocket Limit (see the section below on Out-of-Pocket Limit).

Out-Of-Pocket Limit (Annual Limit on Certain Cost-Sharing).

1. The Plan has an Out-of-Pocket Limit (also referred to as an Out-of-Pocket Maximum) which limits annual cost-sharing for covered essential health benefits received from in-network providers related to Medical PPO Plan coinsurance and copayments. See the applicable Schedule of Medical Benefits for details on the amount of the annual Out-of-Pocket Limit.
   a. The Out-of-Pocket Limit is accumulated on a calendar year basis.
   b. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
   c. The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.
   d. Covered out-of-area services along with covered emergency services performed in an Out-of-Network Emergency Room will apply to meet the in-network Out-of-Pocket Limit on cost-sharing.
   e. The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.
   f. Expenses for covered mental health and substance use disorder benefits count toward the Out-of-Pocket Limit in the same manner as those for covered medical expenses.
2. **The Out-of-Pocket Limit does not include or accumulate**:
   a. Premiums or Self-Payment amounts,
   b. Expenses for medical services or supplies that are not covered by the Plan,
   c. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers,
   d. Expenses for the use of non-network providers, except non-network emergency services performed in an Emergency Room,
   e. Charges in excess of the Medical Plan's Maximum Benefits,
   f. Expenses that are not considered to be essential health benefits,
   g. Dental Plan and Vision Plan expenses.

Maximum Plan Benefits.

1. **Types of Maximum Plan Benefits**: There are various types of maximum amounts of benefits payable by the Plan on account of medical expenses incurred by any Covered Individual under this Plan. They are described in detail in the following sections and they include the Limited Overall Maximum Plan Benefit and Annual Maximum Plan Benefit.
2. **Limited Overall Maximum Plan Benefits:** Certain Plan benefits are subject to limitations that are not considered Lifetime maximums or Annual maximums. These other types of maximums are referred to under this Plan as Limited Overall Maximums. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of these maximums are identified in the applicable Schedule of Medical Benefits. For example, the travel benefit per transplant. Once the Plan has paid the Limited Overall Maximum Plan benefit for any of those services or supplies on behalf of any Covered Individual, it will not pay any further Plan benefits for those services or supplies on account of that Covered Individual.
3. **Annual Maximum Plan Benefits:** Plan benefits for certain Eligible Medical Expenses are subject to Annual Maximums per Covered Individual or family during each Calendar Year. Once the Plan has paid the Annual Maximum Plan Benefit for any of those services or supplies on behalf of any Covered Individual or family, it will not pay any further Plan benefits for those services or supplies on account of that Individual or family for the balance of the Calendar Year. For example, outpatient rehabilitation visits. The services or supplies that are subject to Annual Maximum Plan Benefit are identified in the applicable Schedule of Medical Benefits.

Information About Medicare Part D Prescription Drug Plans For Individuals With Medicare.

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits. **It has been determined that the prescription drug coverage is "creditable" in the Medical PPO Plan and Kaiser HMO Plans.** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Part D Prescription Drug Plan (PDP) during Medicare's annual enrollment period (generally October 15 through December 7th of each year).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If however you keep this Plan coverage and also enroll in a Medicare Part D Prescription Drug Plan (PDP) you will have dual prescription drug coverage. This Plan does not coordinate its Prescription Drug Program drug payments with Medicare. See the Coordination of Benefits Article for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare Part D Prescription Drug Plan (PDP) you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan.

Medicare-eligible individuals can enroll in a Medicare Part D Prescription Drug Plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally October 15th through December 7th); or
- for beneficiaries leaving union group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare Part D Prescription Drug Plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare Part D Prescription Drug Plan when first offered that enrollment opportunity, you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

For more information about creditable coverage or Medicare Part D coverage see the Medicare Part D Notice of Creditable Coverage (a copy is available from the Administrative Office (contact information is on the Quick Reference Chart in the front of this document). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

Patient Protection Rights Of The Affordable Care Act.

The Medical PPO plan described in this document does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or Non-Network health care provider; however, payment by the Plan may be less for the use of a Non-Network provider. You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical network at their website listed on the Quick Reference Chart.

The Kaiser HMO Medical Plan, not described in this document, does generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Administrative Office (contact information on the Quick Reference Chart).

You do not need prior authorization from the Fund or the Kaiser HMO Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Administrative Office (contact information on the Quick Reference Chart).

Nondiscrimination in Health Care.

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Coverage Of Certain Preventive Drugs Under The Medical PPO Plan.

For any drug listed below to be covered by the Medical PPO Plan, the drug must be:

1. obtained through the outpatient Prescription Drug Program at a participating network retail pharmacy and
2. presented to the pharmacist with a prescription for the drug from your Physician or Health Care Practitioner.

(Note that while these drugs require a prescription to be payable by this Plan, certain types of insulin are payable by the Plan without a prescription).

The following chart outlines the drugs that are payable by the non-grandfathered Medical PPO Plan in this document, **at no charge when purchased at the Plan's network retail pharmacy location or Mail Order Service**, in accordance with Affordable Care Act regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released Affordable Care Act regulations affecting the coverage of OTC or prescription drugs, this Plan will comply with the new requirements on the date required.

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Drugs in addition to a prescription from your Physician or Health Care Practitioner:
Aspirin	• Beginning 1-1-16, for pregnant women who are at high risk for preeclampsia (a pregnancy complication). • Beginning January 1, 2018, low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	None, if payment parameters are met	For non-pregnant adults: since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months. Beginning on 1-1-16, for pregnant women at high risk for preeclampsia: daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation. The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
FDA-approved contraceptives for females, such as birth control pills, spermicidal products and sponges.	All females	None, if payment parameters are met	Up to a month's supply of FDA-approved contraceptives per purchase (or 3 month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the plan's Prescription Drug Program for females younger than 60 years of age. Generic FDA-approved contraceptives are at no cost to the plan participant when prescribed. Brand contraceptives are payable only if a generic alternative is medically inappropriate.
Folic acid supplements containing 0.4 - 0.8mg of folic acid	All females planning or capable of pregnancy should take a daily folic acid supplement.	None, if payment parameters are met	Excludes women over 55 years of age, and products containing more than 0.8mg or less than 0.4mg of folic acid. Plan covers generic folic acid up to one tablet per day.

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Drugs in addition to a prescription from your Physician or Health Care Practitioner:
Tobacco cessation products (FDA approved)	Individuals who use tobacco products.	None, if payment parameters are met	FDA-approved tobacco cessation drugs (including both prescription and over-the-counter medications) are payable under the plan's Prescription Drug Program, for up to two 90-day treatment regimens per year, which applies to all products. No precertification or prior authorization is required.
Fluoride supplements	For children starting at age 6 months when recommended by provider because the child's primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a physician or Health Care Practitioner as preparation for a payable preventive colon cancer screening test, such as a colonoscopy for individuals age 45-75 years. Two fills per 365 days are covered.
Breast cancer preventive medication	Women who are at increased risk for breast cancer and at low risk for adverse medication effects.	None, if payment parameters are met	Plan covers generic breast cancer preventive drugs such as tamoxifen, raloxifene, or aromatase inhibitors.
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.	None, if payment parameters are met	For adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke), the Plan covers a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening (a lab test) in adults ages 40 to 75 years.
Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy	Persons at increased risk of HIV acquisition	None, if payment parameters are met	Generic antiretroviral therapy (Rx): • Emtricitabine/tenofovir disoproxil fumarate 200 mg-300 mg

Schedule Of Medical Benefits.

A schedule of the Medical PPO Plan benefits appears on the following pages in a chart format. Each of the Plan's Medical Benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided In-Network (when you use In-Network Providers) and Out-of-Network (when you use Non-Network Providers) are shown in the subsequent columns.

Out-of-Pocket Limits are listed first because these categories of benefits apply to most (but not all) health care services covered by the Plan. They are followed by descriptions, appearing in **alphabetical** order, of all other benefits for specific health care services and supplies that are frequently subject to limitations and exclusions.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Medical PPO Plan Exclusions Article of this document to see if they are excluded.

Time Limit For Initial Filing Of Health Claims

All medical PPO plan, Dental PPO Plan and Vision PPO Plan claims must be submitted to the Plan **within 12 months** from the date of service.

No Plan benefits will be paid for any claim submitted after this period. See also the Claim Filing and Appeal Information Article for more information. Also review the section toward the end of that Article on "Limitation On When A Lawsuit May Be Started."

ARTICLE 6: SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

This chart explains the benefits payable by the PPO Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. When deductibles apply, they apply to all benefits in this Schedule unless noted otherwise. If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Annual Deductible • The deductible is the amount you must pay each calendar year for covered medical expenses before the Plan begins to pay benefits. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. The amount applied to the Deductible is the "Allowed Charge" amount as defined in the Definitions Article of this document.		No annual Deductible	
Annual Out-of-Pocket Limit • The Out-of-Pocket Limit is the most cost-sharing you pay for in-network medical plan coinsurance, and copayments each calendar year. • The Out-of-Pocket Limit is accumulated on a calendar year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services. • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, **no one individual in the family will be required to accumulate more than the individual out-of-pocket limit**. • Expenses for mental health and substance use disorder benefits and outpatient prescription drug benefits will accumulate to meet the annual Out-of-Pocket Limit in the same manner as those for covered medical expenses.	• Copayments and coinsurance related to In-Network essential health benefits for Medical Plan expenses accumulate to the Out-of-Pocket Limit. • Covered out-of-area services along with emergency services performed in an Out-of-Network Emergency Room will apply to meet the in-network Out-of-Pocket Limit on cost-sharing. • **The Out-of-Pocket Limit does not include or accumulate**: 1. Premiums or self-payment amounts 2. Expenses for medical services or supplies that are not covered by the Plan 3. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers 4. Expenses for the use of non-network providers, except non-network emergency services performed in an Emergency Room 5. Charges in excess of the Medical Plan's Maximum Benefits 6. Expenses that are not considered to be essential health benefits 7. Dental Plan and Vision Plan expenses.	$1,000 per person $2,000 per family No one individual in the family will be required to accumulate more than the individual out-of-pocket limit each year	Not applicable

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

This chart explains the benefits payable by the PPO Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. When deductibles apply, they apply to all benefits in this Schedule unless noted otherwise. If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Acupuncture Services	• Acupuncture is covered to a maximum of five (5) visits/person per calendar year.	Office Visit: 100% after $10 copay. Acupuncture Treatment: No charge.	80%
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.		**Allergy Testing and Allergy Serum:** 80% **Allergy Injections when part of an office visit:** 100% after $10 copay. **Allergy injections when no office visit charged:** 100% after $10 copay.	**Allergy Testing, Allergy Serum, and Allergy Injections:** 80%
Ambulance Services • **Ground vehicle transportation** to the nearest appropriate facility as medically necessary for treatment of a medical Emergency, acute illness or inter-health care facility transfer. • **Air/sea transportation** only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.	• Expenses for ambulance services are covered only when those services are for an **Emergency** as that term is defined in the Definitions Article of this document or for medically necessary inter-facility transport. • No coverage for non-emergency transportation except medically necessary inter-health care facility transfer (as explained to the left).	Emergency Transport: 100%	Emergency Transport: 100%
Ambulatory Surgery	• See the Outpatient Surgery row in this Schedule.		
Bariatric Services	• See the Weight Management row in this Schedule.		

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

This chart explains the benefits payable by the PPO Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. When deductibles apply, they apply to all benefits in this Schedule unless noted otherwise. If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Behavioral Health Services: **(Mental Health and Substance Abuse Treatment)**	**Employee Assistance Program (EAP) Services:** Your employer may offer access to an EAP with professional confidential counseling services at no cost to you. The EAP Program is not associated with or sponsored by this Plan. The phone number for certain EAP programs is listed on the Quick Reference Chart in the front of this document.		

• The following behavioral health benefits are available:
  • Outpatient Visits.
  • Inpatient Admission including residential treatment program.
  • Other outpatient services: intensive outpatient program and partial hospitalization
  • Applied Behavioral Analysis (ABA) Therapy (as defined in the Definitions Article of this document)
	• For assistance locating behavioral health providers best qualified to treat your needs please contact the Behavioral Health Program administrator as listed on the Quick Reference Chart in the front of this document.
	• **Precertification required for inpatient hospital admission and residential treatment to avoid a financial penalty**. See Article 4.
	• Partial hospitalization means treatment of mental, nervous, or emotional disorders and substance abuse for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period.
	• Behavioral Health **residential treatment program** is covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates.
	• Outpatient prescription drugs for Behavioral Health are payable under Drugs in this Schedule of Medical Benefits.
	• For assistance with tobacco addiction, see the Smoking/Tobacco Cessation row of this Schedule.
		Office Visit:
		100% after $10 copay.
		
		Inpatient Admission and Residential Treatment Program:
		100%
		
		Other outpatient services:
		100%
			Office Visit:
			80%
			
			Inpatient Admission and Residential Treatment Program:
			80%

Blood Transfusions • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician or Health Care Practitioner. • Expenses related to autologous blood donation (patient's own blood) are covered.	100%	80%
Cardiac Rehabilitation	• See the "Rehabilitation Services: Cardiac" row in this Schedule.		
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician or Health Care Practitioner in a Hospital, Health Care Facility, Physician's or Health Care Practitioner's office or at home.		100%	80%
Chiropractic Services	• See the Spinal Manipulation row in this Schedule.		

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

This chart explains the benefits payable by the PPO Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. When deductibles apply, they apply to all benefits in this Schedule unless noted otherwise. If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Colonoscopy, Screening • No charge for the bowel prep medication prescribed for use prior to a screening colonoscopy, anesthesia services or the cost of polyps removed during a screening colonoscopy.	• See also the Wellness row in this Schedule. • For non-screening colonoscopy see the Radiology services row.	100%	No coverage.
COVID-19 Related Services • See also the Definition of COVID-19 Related Services in the Glossary	• Coverage of services related to COVID-19 testing, diagnosis and treatment is effective only for services received on or after March 1, 2020 through the end of the Emergency Period during which the federal government has announced a National Emergency.	**COVID-19 related services:** 100%	**COVID-19 related services:** 100%

Corrective Appliances: (Prosthetic & Orthotic Devices, other than Dental)
• Corrective appliances includes prosthetics devices and Orthotics devices such as casts, splints, braces and crutches as follows:
  • Rental or purchase of standard model.
  • Adjustment or servicing of the device.
• Colostomy or ostomy (orthotic) supplies.
	• Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner.
	• **Non-foot Orthotics** are covered, such as a back, knee, ankle or wrist brace. Up to two (2) **foot orthotics** are covered whether the orthotics are permanently fastened to an orthopedic brace or used in place of surgery.
	• **Prosthetic Devices** are payable including the temporary and definitive (permanent) appliance, and necessary supplies.
	• See the exclusions related to Corrective Appliances in the Medical PPO Plan Exclusions Article. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions Article.
		100%	80%

Dialysis • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician or Health Care Practitioner in a Hospital, Health Care Facility, Physician's or Health Care Practitioner's office or at home.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. • See also the Coordination of Benefits Article that discusses what this Plan pays when you are also Medicare eligible.	100%	80%
Dietitian/Nutritionist Services	• Charges made by a licensed or certified dietitian or nutritionist for the non-surgical treatment of obesity or behavioral health condition is payable. • Certain dietary counseling may be payable as a Wellness service. See also the Wellness row for coverage for intensive behavioral counseling. See also the Weight Management row.	100%	80%

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

This chart explains the benefits payable by the PPO Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. When deductibles apply, they apply to all benefits in this Schedule unless noted otherwise. If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider

Drugs (Outpatient Prescription Medicines)
• Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
• Coverage is provided for insulin, insulin syringes, diabetic supplies and FDA-approved female contraceptives.
• Contact the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document) for: the
  • **preferred drug formulary,**
  • **drug precertification/prior authorization** required for weight control drugs, specialty drugs, and some topical drugs,
  • **quantity limits,**
  • **step therapy** and
  • **information on Specialty drugs**.
• **Specialty drugs** are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are products derived from living organisms used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, hepatitis, or rheumatoid arthritis. These drugs need precertification and are managed because they often require special handling, are date sensitive.
• The prescription drug benefits of this Plan are **creditable** with Medicare Part D prescription drug coverage.
• **Certain over-the-counter (OTC) drugs are covered only under this Outpatient Prescription Drug Program at no charge** in compliance with Affordable Care Act regulations. See Article 4 for details.
• Certain CDC recommended vaccinations are payable at 100%, no cost-sharing when obtained at an in-network retail pharmacy.
• Drugs not yet approved by the FDA are not covered. New FDA-approved drugs will be covered unless an amendment states otherwise or the class of drug is excluded.
	Benefits for prescription drugs are provided through the Plan's Prescription Drug Program whose name is listed on the Quick Reference Chart in the front of this document.
	• **Retail Drugs**: To obtain up to a 30-day supply of medicine present your ID card to any in-network retail pharmacy. Contact the Prescription Drug Program (whose name is listed on the Quick Reference Chart) for the location of in-network retail pharmacies.
	• **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Not all medicines are available via mail order. Check with the Prescription Drug Program for further information. To use the mail order service:
	  a) Have your doctor write the prescription for a 90-day supply, with the appropriate refills.
	  b) Mail your prescription, copay & mail order form to the Mail Order Services of the Prescription Drug Program whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Drug Program. Allow up to 14 days to receive your order.
	• **Generic Requirement:** If a generic equivalent is available, you must fill the generic or be responsible for the cost difference between the price of the brand name drug and the generic drug plus the copayment.
	• **Mandatory Mail Order Provision:** If you fill a maintenance medication at a retail pharmacy (instead of the mail order) more than two times, your copay will increase to 50% of the cost of the medication.
	• The **Quantity Limitation Program** is designed to protect patients taking excessive amounts of narcotic pain relievers, migraine medications, respiratory and asthma medications, or sedative hypnotics. Any usage that exceeds FDA guidelines will require prior authorization from the Prescription Drug Program.
	• **Step Therapy Program:** Proton Pump Inhibitor (PPI) drugs, such as Nexium, Prevacid and Prilosec, are used to block the production of stomach acid. The Step Therapy Program ensures that these drugs are used in accordance with FDA guidelines. The Step Therapy Program also includes cholesterol-lowering drugs (statins), sleep aids, SSRI antidepressants, COX-2 anti-inflammatory drugs and steroid nasal sprays.
	• Coverage is extended for **tobacco cessation products** intended to assist an individual to stop smoking or using tobacco products. You must present a written prescription from a physician or Health Care Practitioner for tobacco cessation products to the retail pharmacist. You may also submit a prescription order through the mail order program. See also the Smoking/Tobacco Cessation row of this Schedule for payment for smoking/tobacco cessation counseling.
	• No charge for brand contraceptives if a generic contraceptive is unavailable or is medically inappropriate. The attending provider determines medical necessity for FDA-approved female contraceptives.
	• Copayments for drugs accumulate to the Medical PPO Plan's out-of-pocket limit.
	• No coverage for sexual disorder drug treatment, or any prescription filled in a foreign country. See also exclusions under Drugs (Medicines) in the Medical PPO Plan Exclusions Article.
	• Certain covered drugs are not filled or administered through the Prescription Drug Program, such as intrathecal administration of a class of drugs called "survival motor neuron-2 (SMN2)-directed antisense oligonucleotides," which includes drugs such as Spinraza (nusinersen). Covered drugs not filled or administered through the Prescription Drug Program may be submitted for payment to the Medical Plan Claim Administrator.
		Retail Prescription (up to 30-day supply):
		$5 copay for generic. (Brand name if no generic equivalent.)
		If you fill a maintenance medication at a retail pharmacy more than two times, your copay will increase to 50% of the cost of medication.
		
		Specialty drugs: $0 copay for generic.
		(Brand name if no generic equivalent.)
		
		Mail Order Maintenance Choice (up to 90-day supply):
		$0 copay for generic
		(Brand name if no generic equivalent).
		
		No Charge at In-network Retail/Mail Order Location:
		When prescribed by a Physician, no charge for:
		• female FDA-approved generic contraceptives
		• tobacco cessation products
		• certain over the counter drugs mandated by the Affordable Care Act (See Article 4)
		• certain drugs to reduce the risk of breast cancer (generic tamoxifen or raloxifene) prescribed for women who are at increased risk of breast cancer and low risk for adverse medication effects.
		
		Direct Member Reimbursement for use of an Out-of-Network Retail Pharmacy:
		If you fill a prescription at an Out-of-Network pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimbursement (DMR) process as listed on the Quick Reference Chart. DMR forms may be obtained from the Prescription Benefit Manager (PBM) or the Fund's website. For eligible prescriptions, you will be reimbursed according to the amount that would have been allowed had you used an In-Network retail pharmacy. The Plan pays 75% of the Allowed amount, you pay 25% plus any amount over the Allowed amount.
		
		Out-of-Network Mail Order/Maintenance:
		Not covered.	

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider

Durable Medical Equipment (DME)
• Coverage is provided for:
  • Purchase of standard model;
  • Purchase or rental of DME at the option of the medical plan claims administrator;
  • Adjustment or servicing.
• Coverage is provided for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration.
	• To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions Article.
	• Durable Medical Equipment is covered only when its use is medically necessary and it is ordered by a Physician or Health Care Practitioner.
	• For participants or dependents who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus supplies necessary to operate the breast pump. Generally, a breast pump is payable once each 36 months. Rental versus purchase is at the option of the Plan. Repair is payable when medically necessary. Includes comprehensive lactation support and counseling by a trained provider while breastfeeding.
	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Medical PPO Plan Exclusions Article.
		100%	80%

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Emergency Room & Urgent Care Services (facility fees) • Hospital emergency room (ER) for "Emergency Services" (as that term is defined in the Plan). • Use of an Urgent Care facility. • Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit. • (See also the Ambulance row of this Schedule.)	• There is no requirement to precertify the use of a hospital-based emergency room visit. • The plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with Affordable Care Act regulations. See the definition of Allowed Charge in the Definitions Article or contact the Administrative Office for more details on what the Plan allows as payment for use of an Out-of-Network emergency room. • Coverage of services related to COVID-19 testing, diagnosis and treatment is effective only for services received on or after March 1, 2020 through the end of the Emergency Period during which the federal government has announced a National Emergency.	**Urgent Care Services:** 100% after $10 copay. **Non-Emergency Use of Emergency Room:** 100% after a $100 copay. **Emergency Use of Emergency Room Services:** 100% after $25 copay for ER visit, (if not admitted to the Hospital). **COVID-19 related services:** 100% 100% (copay waived) for ER visit if admitted to the Hospital, or if you seek treatment at the emergency room within 24 hours of an accident.	**Urgent Care Services**: 80% **Non-Emergency Use of Emergency Room:** 100% after a $100 copay. **Emergency Use of Emergency Room Services:** 100% after $25 copay for ER visit (if not admitted to the Hospital). **COVID-19 related services:** 100% 100% (copay waived) for ER visit if admitted to the Hospital, or if you seek treatment at the emergency room within 24 hours of an accident.

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Endoscopy Facility (Outpatient) • Endoscopy is a procedure to evaluate the interior surfaces of an organ by inserting a device such as an endoscope into the body, including but not limited to the lungs, intestines, bladder, sinus, etc.	• See also the Colonoscopy (screening) benefit in the Wellness row of this Schedule. • See the Physician row of this Schedule for coverage of professional fees associated with an endoscopy procedure.	**Facility Fees:** 100%	**Facility Fees**: 80%
Family Planning and Contraceptive Services • Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure). There is no cost-sharing for female sterilization procedures and these benefits will be paid at 100% when provided by in-network providers. • FDA-approved female contraceptives and counseling such as oral birth control pills/patch, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD), cervical cap, contraceptive ring, diaphragm, implantable birth control device/service.	• Certain FDA-approved female contraceptives are to be obtained from the Prescription Drug Program and are payable under the Drugs (Medicines) row in this Schedule. There is no cost-sharing for generic FDA-approved female contraceptives and these benefits will be paid at 100% for services received from In-Network providers. Brand drug is payable if a generic drug is medically inappropriate. • See the Infertility Services row of this Schedule for coverage of infertility. • No coverage for the treatment of sexual dysfunction. • See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Medical PPO Plan Exclusions Article.	**FDA-approved female contraceptive services:** No charge. **Female sterilization:** No charge. **Male sterilization**: Generally no charge. Coverage is based on the type of service and where provided; Contact the Medical Plan Claims Administrator in Quick Reference Chart for specifics.	**FDA-approved female contraceptive services:** 80% **Female and Male sterilization**: Generally 80%. Coverage is based on the type of service and where provided; Contact the Medical Plan Claims Administrator in Quick Reference Chart for specifics.

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Genetic Testing and Counseling The genetic testing payable under this Plan is for: • state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers); • fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee; • tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; • the genetic testing is recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis; • genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Affordable Care Act regulations (see the Wellness row in this Schedule). • the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants who have all the following: a. the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and b. the covered individual displays clinical features/symptoms, or is at direct risk of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and c. the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being delivered to the covered individual.	• **Genetic Counseling** is payable when ordered by a Physician or Health Care Practitioner, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by this Plan or as required under the Affordable Care Act. • See the definitions of Genetic Counseling and Genetic Testing in the Definitions Article. • See the Medical PPO Plan Exclusions Article for exclusions relating to Genetic Testing and Counseling, other than those indicated here as covered. • No coverage for Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents. No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan.	100%	80%

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Hearing Services • Hearing Testing (audiology examination). • Hearing Aids	• When recommended by an otolaryngologist physician, covered at 100% for initial pair of hearing aids, provided they were recommended by a Physician certified as an otolaryngologist. This is the only one allowed under the Plan. However, for children through age 26 the Plan covers one (1) hearing aid per ear every three (3) years. • Covered at 100% after copayment for hearing exam associate with hearing aids. • Routine hearing exams are not covered. • Certain hearing screening for newborns is payable at no charge. See the Wellness row in this Schedule. • Medically necessary cochlear implant and similar implantable hearing device payable as a prosthetic device. See the Corrective Appliances row in this Schedule. • No coverage for hearing aid batteries, and other hearing aid accessories including Dri-Aid kits for hearing aid moisture removal and phone pads.	**Hearing Aids:** 100% up to the limit described to the left **Hearing (Audiometric) Exam**: 100% after a $10 copay	**Hearing Aids:** 100% up to the limit described to the left **Hearing (Audiometric) Exam**: 80%
Home Health Care and Home Infusion Services • Part-time, intermittent **Skilled Nursing Care** services and medically necessary supplies to provide Home Health Care or home infusion services. If person requires skilled nursing care and visiting nursing care is not adequate, private duty nursing outpatient care by an RN or LVN is covered. • Certified nurse aide (home health aide) services under the supervision of a registered nurse are payable.	• **Precertification required to avoid a financial penalty**. See Article 4. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner and provided by a licensed home health care agency. • Each home health aide visit of up to 4 hours = 1 visit. • Home Hospice coverage is payable under Hospice benefits. • Home Physical Therapy services coverage is payable under the Rehabilitation Services benefits.	100%	80%
Hospice • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the definition of Hospice in the Definitions Article of this document.	• No coverage for funeral arrangements, bereavement or pastoral counseling, financial or legal counseling, estate planning or will drafting, caretaker or homemaker services or respite care. • Bereavement counseling, beyond that which may be included as part of the Hospice provider's normal services, is payable under the Behavioral Health benefits of this Plan.	100%	80%

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Hospital Services (Inpatient), including licensed birthing center • Daily average room & board facility fees in a semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit (ICU), cardiac/coronary care unit). • Lab/x-ray/diagnostic services. • Related medically necessary ancillary services (e.g., prescriptions, anesthesia, blood, supplies). • Routine nursery care of a newborn child and newborn circumcision.	• **Precertification required to avoid a financial penalty**. See Article 4. • Private room is covered only if medically necessary or if the facility does not provide semi-private rooms. • A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Utilization Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the associated dental professional fee services provided while at a hospital or outpatient surgery facility as those fees would be paid by the patient's Dental Plan coverage.	100%	80%
Infertility Services • Expenses for the treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer • Donor egg/semen, cryostorage of egg and/or sperm (for up to one year), ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures.	• Benefits available to Participants and Spouses. • **Lifetime maximum for services is $25,000 per Participant.** • Services are payable if received by the Participant or Spouse, the benefits available to Participants and Spouses **do not** combine to $50,000. • Services and expenses for Dependent Children are not covered. • Expenses related to egg and/or sperm storage longer than one year are not covered • Benefits subject to precertification. • Medical Necessity as determined by the Claims Administrator, subject to precertification and according to the Claims Administrator's coverage criteria.	100%	80%

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Laboratory Services (Outpatient) • Technical and professional fees. • Inpatient Laboratory Services are covered under the Hospital Services row of this Schedule of Medical Benefits.	• Covered only when ordered by a Physician or Health Care Practitioner. • Some laboratory services are payable under the Wellness benefits in this Schedule. • Coverage of services related to COVID-19 testing, diagnosis and treatment is effective only for services received on or after March 1, 2020 through the end of the Emergency Period during which the federal government has announced a National Emergency.	100% $10 copay, if performed as part of physician office visit and billed by a physician or health care practitioner COVID-19 related services:100%	80% COVID-19 related services:100%

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Maternity Services • Hospital and Birth (Birthing) Center charges and Physician and Licensed Nurse Midwife fees for medically necessary maternity services. • Plan benefits are payable for charges incurred by a Participant as a result of pregnancy, childbirth or a related medical condition. • **See the Eligibility Article on how to enroll a Newborn Dependent Child(ren).** • Elective induced abortion. • See the Genetic Testing row of this Schedule for additional information. • For participants and dependents who are breastfeeding, the Plan pays for comprehensive lactation support and counseling by a trained Breastfeeding/lactation Educator (as defined in this Plan) while breastfeeding. Also, coverage is provided for a standard manual or standard electric breast pump, plus necessary breast pump supplies. Generally, a breast pump is payable once each 36 months. This includes comprehensive lactation support and counseling by a trained provider, during pregnancy and/or in the postpartum period. Rental versus purchase is at the option of the Plan. Repair is payable when medically necessary. • Under this Plan, there is no requirement to select a Primary Care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.	• Pregnancy-related care is covered for a Participant, Dependent Spouse, or Dependent Child. No coverage is provided for the baby of a Dependent Child. • Certain prenatal care/maternity related preventive care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to screening for gestational diabetes, for participants and dependents who are breastfeeding there is coverage for breastfeeding supplies and rental of breastfeeding equipment, and comprehensive lactation support and counseling. These services are covered under the Wellness/Preventive Services category without cost-sharing for a female when obtained from in-network providers. In-network providers are listed on the network directory described on the Quick Reference Chart. • **Hospital Length of Stay for Childbirth:** This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). • See the exclusions related to Maternity Services in the Medical PPO Plan Exclusions Article.	**First prenatal office visit:** 100% after $10 copy per visit. Thereafter, **prenatal office visits,** no charge. **Breast Pump and supplies and lactation counseling:** No charge. **All other Maternity Services**: • Ultrasounds and other non-preventive maternity services: 100% • Facility fees for delivery: 100% • Professional fees for delivery: 100%,	**Prenatal Visits are covered as part of Global Maternity Services**: 80% **Breast Pump and supplies and lactation counseling**: 80% **All other Maternity Services:** • Ultrasounds and other non-preventive maternity services: 80% • Facility fees for delivery: 80% • Professional fees for delivery: 80%

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Nondurable Supplies
• Coverage is provided for supply of:
  • Sterile surgical supplies used immediately after surgery.
  • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
  • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
  • Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under this benefit or under the Prescription Drug Program.
	• Nondurable Supplies are goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use.
	• Only the nondurable supplies listed to the left are covered by the Plan.
		100%	80%

Obesity Services	• See the Weight Management row of this Schedule.		

Oral and Craniofacial Services
• Accidental Injury to Teeth/Jaw
• Oral and/or Craniofacial Surgery.
	• See the exclusions related to Dental Services in the Medical PPO Plan Exclusions Article.
	• Treatment of Accidental Injuries to the Teeth/Jaw: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met:
	  • The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and
	  • The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
	  • The dental treatment will return the person's teeth to their pre-injury level of health and function. See also the definition of Injury to Teeth in the Definitions Article.
	• Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute injury and for reconstructive but not cosmetic purposes.
	• No coverage for dental services such as removal of partial bony wisdom teeth, root canal, gingivectomy, dental abscess treatment or treatment for temporomandibular joint (TMJ) dysfunction. See the Dental PPO Plan Article.
		• Office Visits: 100% after $10 copay per visit.
		• Non-office visit professional fees from a Physician or Health Care Practitioner: 100%
		• Hospital or Outpatient surgery facility fees: 100%
			80%

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

This chart explains the benefits payable by the PPO Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. When deductibles apply, they apply to all benefits in this Schedule unless noted otherwise. If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Outpatient (Ambulatory) Surgery Facility • Ambulatory (Outpatient) Surgical Facility (e.g. surgicenter, same day surgery). • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Utilization Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the associated dental professional fee services provided while at a hospital or outpatient surgery facility as those fees would be paid by the patient's Dental Plan coverage. • Outpatient Pain Management services are **not payable when obtained from out-of-network** providers.	100%	80% **Outpatient Pain Management services:** Not covered.

Physician and Other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility, retail medical clinic or other covered health care facility location.
• Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon
  • Assistant surgeon (if medically necessary)
  • Anesthesia by Physicians and Certified Registered Nurse Anesthetists
  • Pathologist
  • Radiologist
  • Podiatrist
  • Physician Assistant, Nurse Practitioner, Nurse Midwife
  • Breastfeeding/Lactation Educator
• See also the Family Planning, Maternity and Wellness rows of this Schedule where certain preventive services are payable without cost-sharing when obtained from in-network providers.
• 98point6 virtual office visits are payable. See the Quick Reference Chart for more information.
• See the Emergency Services row for payment of providers in an emergency room.
	• **Precertification required for certain services to avoid a financial penalty.** See Article 4.
	• **Assistant Surgeon fees** will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon.
	• See the definition of Physician, Health Care Practitioner and Surgery in the Definitions Article.
	• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery" in the Definitions Article.
	• The plan does not require the selection of a primary care physician (PCP) therefore you have the right to be seen by any provider who participates in the Plan's medical PPO network and who is available to accept you or your eligible family members.
	• You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the medical plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical plan PPO network at their website listed under PPO Networks on the Quick Reference Chart in this document.
	• Medically necessary medical treatment of the foot is payable from a Podiatrist for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
	• Outpatient Pain Management services are **not payable when obtained from out-of-network** providers.
	• Coverage of services related to COVID-19 testing, diagnosis and treatment is effective only for services received on or after March 1, 2020 through the end of the Emergency Period during which the federal government has announced a National Emergency.
		Office visit: 100% after $10 copay per visit.
		Virtual Visit through 98point6: No charge.
		COVID-19 related services: 100%
		All other covered professional fees from a Physician or Health Care Practitioner: 100%.
			Office visit: 80%
			Virtual visits through Out-of-Network providers: Not covered
			COVID-19 related services: 100%
			Outpatient Pain Management services: Not covered.

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered under the Wellness Programs described in this Schedule.	100% $10 copay if performed as part of office visit and billed by a physician or health care practitioner	80%

Reconstructive Services and Breast Reconstruction After Mastectomy
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any Covered Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • reconstruction of the breast on which the mastectomy was performed;
  • surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
• Reconstructive Surgery only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly that causes a functional defect.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Medical PPO Plan Exclusions Article. Cosmetic and Dental (including Orthognathic) services are excluded from coverage.
	• Breast reduction guidelines: A female employee or dependent seeking coverage for breast reduction surgery must submit, to the Administrative Office, information and medical documentation which support the medical necessity of the recommended procedure, prior to the expenses being incurred. This must be certified by a medical doctor who performs such surgical procedures.
	• Reconstructive services are payable if medically necessary because of congenital disease or anomaly of a Dependent Child that has resulted in a functional defect. Non-functional defects resulting from congenital malformations of a Dependent Child will be covered after review by the Board of Trustees or its designee, on a case by case basis.
		• Office Visits: 100% after $10 copay per visit.
		• Non-office visit professional fees from a Physician or Health Care Practitioner: 100%
		• Hospital or Outpatient surgery facility fees: 100%
			80%

Rehabilitation Services: Cardiac • **Cardiac Rehabilitation** is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.).	• Cardiac Rehabilitation programs must be ordered by a Physician or Health Care Practitioner. • Seethe definition of Cardiac Rehabilitation in the Definitions Article.	Outpatient Cardiac Rehab: 100% after $10 copay per visit.	80%

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Rehabilitation Services (Physical, Occupational & Speech Therapy) • Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician or Health Care Practitioner. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.** • Outpatient physical therapy performed in conjunction with Spinal Manipulation services is subject to the Plan's limitations for Spinal Manipulation services.	• **Precertification required for inpatient admission to avoid a financial penalty**. See Article 4. • Rehabilitation services are covered only when ordered by a Physician or Health Care Practitioner. • **Outpatient Rehabilitation Services (any combination of Physical, Occupational and Speech Therapy) are payable up to 50 visits per person per calendar year, no limit for treatment of behavioral health condition.** • Outpatient Physical Therapy or Occupational Therapy services prescribed by a Physician or Health Care Practitioner are payable up to two (2) consecutive months when in the judgment of the Physician, significant improvement can be obtained. Additional need for therapy must be certified by the attending Physician to be medically necessary. When prescribed or provided by a Physician or Health Care Practitioner, the following types of therapy are covered: 1. Physical Therapy performed by a Physician or a registered physical therapist. 2. Occupational Therapy performed by a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA). 3. Speech Therapy performed by a certified speech therapist. • Physical Therapy and Occupational Therapy which are prescribed by a Physician or Health Care Practitioner in lieu of non-medical treatment (e.g., exercise) are not considered Medically Necessary and reasonable treatment and would not be payable by the Plan. • Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist: 1. for children for childhood developmental speech delays and disorders, 2. for adults/children to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. • No coverage for habilitation services. • Benefits are not payable for Physical, Occupational or Speech Therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected. • Outpatient Pain Management services are **not payable when obtained from out-of-network** providers.	Outpatient Rehab: 100% after $10 copay per visit. Inpatient Rehabilitation: 100%	80% **Outpatient Pain Management services:** Not covered.
Residential Treatment Program	• See the Behavioral Health Services row in this Schedule.		
Respite Care	• See the Hospice row in this Schedule.		

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Routine Costs • Routine costs associated with an individual's participation in an "approved clinical trial" related to cancer or other life-threatening illnesses.	• See the definition of "Experimental" for information on the routine costs that are payable by the plan. • The Plan does not cover non-routine services and supplies, such as: (1) the investigational items devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.	• Office Visits: 100% after $10 copay per visit. • Non-office visit professional fees from a Physician or Health Care Practitioner: 100% • Hospital or Outpatient surgery facility fees: 100%	80%
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility (Long Term Acute Care – LTAC).	• **Precertification required to avoid a financial penalty**. See Article 4. • Services must be ordered by a Physician or Health Care Practitioner. • To determine if a facility is a skilled nursing or subacute facility see the Definitions Article of this document.	100%	80%
Smoking/Tobacco Cessation • Coverage is provided for free tobacco cessation counseling sessions through the In-network Physician or Health Care Practitioner, and for tobacco cessation products when prescribed.	• Tobacco cessation counseling sessions may be covered under your employer's Employee Assistance Program (EAP), if available. • Products used for smoking/tobacco cessation are payable by the Plan when prescribed. (Refer to the Drug row in this Schedule of Medical Plan Benefits for a complete description of the outpatient drug benefits.) • Physician office visit for smoking/tobacco cessation is covered at no charge if an in-network provider is used. • The Plan covers tobacco use screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage to aid in the cessation of tobacco products includes: 1. Screening for tobacco use; 2. Preventive counseling visits; 3. Treatment visits; and 4. Class visits.	Counseling: 100% for office visits with an in-network physician or Health Care Practitioner, up to 8 visits per 12 months.	No coverage
Spinal Manipulation Services • Spinal Manipulation Services (from a Physician or Chiropractor) including related ancillary services (e.g., office visit, x-rays). • Chiropractic care means only manipulations and/or mobilizations performed by a Physician or Chiropractor.	• Services are payable to **a maximum of 12 visits** per person per calendar year In-Network or Out-of-Network.	100% after a $10 copay per visit.	80%

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Surgeon, Assistant Surgeon	• See the Physician row in this Schedule.		
Transplants, Organ and Tissue • Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue (specifically cornea, bone marrow, peripheral stem cells, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin) along with the facility and professional services, FDA approved drugs, and medically necessary equipment and supplies. • Organ or tissue testing, procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor. • Reasonable and necessary expenses incurred by a donor who **is covered** by this Plan, without any Coinsurance applicable to those expenses. • Reasonable and necessary expenses incurred by a donor who **is not covered** by this Plan, without any Coinsurance applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.	• For Institute of Excellence transplant locations, contact the Medical Plan Claims Administrator (see the Quick Reference Chart). • **For Transplant services, coverage is permitted for certain travel benefits when the transplant occurs at an Institute of Excellence location and such transplant must occur in a location where the participant does not reside:** The following transportation, lodging expenses will be reimbursed up to the maximum benefits for each covered transplant procedure completed. If the recipient of the covered transplant procedure is an adult, costs of transportation to and from the site of the covered transplant procedure for the recipient and one other individual will be reimbursed. If the recipient of the covered transplant procedure is a minor, costs of transportation to and from the site of the covered transplant procedure for the recipient and two other individuals will be reimbursed. All reasonable and necessary lodging expenses incurred, up to a daily maximum of $200.00, by said individual(s) accompanying the recipient will be reimbursed. The aggregate sum of all costs of transportation, and lodging is payable at 100% to a maximum of $10,000 per transplant, thereafter the Plan pays 10%. • Donor expenses are payable at 100%. Donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan. • See the specific exclusions related to Experimental and Investigational Services and Transplants in the Medical PPO Plan Exclusions Article.	Facility: 100%, when performed in an Institute of Excellence Transplant location Facility: 80%, when performed by any other in-network location	Facility: 80%
Urgent Care Facility	• See Emergency Services row.		

SCHEDULE OF MEDICAL BENEFITS FOR THE PPO PLAN

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Weight Management • Surgical treatment of morbid obesity. • Obesity Preventive Counseling. See also the Wellness row for coverage for intensive behavioral counseling.	• The Plan pays for one surgical procedure for the treatment of Morbid Obesity per person per lifetime (bariatric surgery). Benefits will only be allowed for obesity when a surgical procedure is required due to **morbid** obesity. Morbid obesity is a condition in which persistent and uncontrollable weight gain causes a threat to life. See the definition of Morbid Obesity in the Definitions Article of this document. • Obesity Preventive Counseling is covered with limitations based on age group. Covered expenses include charges made by a physician, licensed or certified dietitian, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services: o An initial medical history and physical exam; o Diagnostic tests given or ordered during the first exam and o Prescription drugs	**Bariatric Surgery:** • Office Visits: 100% after $10 copay per visit. • Non-office visit professional fees from a Physician or Health Care Practitioner: 100%. • Hospital or Outpatient surgery facility fees: 100% **Counseling:** 100%, for visits as follows: age 0-22: unlimited visits; ages 22 and over: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling	**Bariatric Surgery:** 80% **Counseling:** Not covered

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Wellness (Preventive): Well Child Examinations and Immunizations to age 26 years • The wellness/preventive services payable by this plan are designed to comply with Affordable Care Act regulations as outlined to the right. Preventive services are payable without regard to gender assigned at birth, or current gender status. • Routine immunizations are payable, in accordance with the Centers for Disease Control (CDC) recommendations, when they are obtained from an in-network provider or from an in-network retail pharmacy location. • Coverage is provided in primary care clinicians for fluoride varnish applied to the primary teeth of children through age 5. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required. • As a preventive counseling benefit in compliance with the Affordable Care Act (ACA), the Plan covers the following services: for children age 6 years and older with obesity, the Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician.	Coverage is provided for preventive services that are required to be covered under the federal law "Affordable Care Act," in accordance with the US Preventive Services Task Force and Health Resources and Services Administration (HRSA), Bright Futures and immunizations approved by the Centers for Disease Control and Prevention (CDC). For a list of payable services, visit: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.hrsa.gov/womensguidelines/ and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index. • In addition to the wellness services listed on the website above, the Plan will pay for well child office visits. • Certain additional preventive care expenses are payable for all covered females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to screening for gestational diabetes, HPV testing starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, plus annual screening and counseling for interpersonal and domestic violence). • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost-share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, cost-sharing for the diagnostic or therapeutic services will apply. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual cost-sharing including copay/coinsurance. • The Plan will use reasonable medical management techniques - such as age, location for service and test frequency - for consideration of payable preventive services. • Services not covered under the wellness benefit may be covered under another portion of the medical plan. • If there is no network provider who can provide the Affordable Care Act required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. • Certain Over-the-Counter (OTC) Drugs are payable at no charge when prescribed by a Physician/Health Care Practitioner in compliance with the Affordable Care Act law. See Article 4 for more information.	100%	Not covered.

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Benefit Description	Explanations and Limitations	In-Network Preferred Provider (PPO)	Out-of-Network Non-Preferred Provider
Wellness (Preventive): Adult Health Maintenance Examinations and Immunizations • The wellness/preventive services payable by this plan are designed to comply with Affordable Care Act regulations as outlined to the right. Preventive services are payable without regard to gender assigned at birth, or current gender status. • Routine immunizations are payable, in accordance with the Centers for Disease Control (CDC) recommendations, when they are obtained from an in-network provider or from an in-network retail pharmacy location. • No charge for the bowel prep medication prescribed for use prior to a screening colonoscopy, anesthesia services or the cost of polyps removed during a screening colonoscopy. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required. • As a preventive counseling benefit in compliance with the Affordable Care Act (ACA), the Plan covers the following services: for adults (1) with a body mass index of 30 kg/m2 or higher, OR (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m2) or obese (defined as a BMI of 30 kg/m2 or higher) AND have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed **intensive behavioral counseling** interventions.	Coverage is provided for preventive services that are required to be covered under the federal law "Affordable Care Act," in accordance with the US Preventive Services Task Force, the Health Resources and Services Administration (HRSA), Bright Futures and immunizations approved by the Centers for Disease Control and Prevention (CDC). For a list of payable services (including immunizations, mammogram, pap smear, colonoscopy) visit this website: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.hrsa.gov/womensguidelines/ and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index. • In addition to the wellness services listed on the website above, the Plan will pay for these wellness services: an annual wellness/physical exam for adults and annual prostatic specific antigen (PSA) lab test for men, an annual EKG, annual complete blood count, and annual urinalysis. • Certain additional preventive care expenses are payable for all covered females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to well woman visits, screening for gestational diabetes, HPV testing starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, plus annual screening and counseling for interpersonal and domestic violence). • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost-share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, cost-sharing for the diagnostic or therapeutic services will apply. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual cost-sharing including copay/coinsurance. • The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. • Services not covered under the wellness benefit may be covered under another portion of the medical plan. • If there is no network provider who can provide the Affordable Care Act required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. • Certain Over-the-Counter (OTC) Drugs are payable at no charge when prescribed by a Physician/Health Care Practitioner in compliance with Affordable Care Act law. See Article 4 for more information.	100%. Alcohol/drug preventive counseling: 100% for up to 5 visits per 12 months.	Not covered.

ARTICLE 7: MEDICAL PPO PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Medical PPO Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical PPO Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusions.

General Exclusions (applicable to all medical services and supplies).

1. **Autopsy:** Expenses for an autopsy, forensic examination and any related expenses, except as required by the Plan Administrator or its designee.
2. **Costs of Reports, Bills, etc.:** Expenses for preparing or completing forms, medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, interest charges, late fees, prescription refill charges, mileage costs, provider administration fees, concierge/retainer agreement fees, membership/surcharge fees or provider's special plan charging fees to access added benefits and/or photocopying fees. disabled person license plates/automotive forms, concierge/retainer agreement/membership/surcharge fees or provider's special plan charging fees to access added benefits.
3. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: expenses for learning deficiencies, behavioral problems or Special Education, educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, vision therapy, auditory aides, speech aids, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices. Certain educational services may be listed as a covered benefit in the Schedule of Medical Benefits in this document.
4. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation or Maximum Plan Benefit as described in the Medical PPO Plan Benefits Article of this document.
5. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions Article of this document.
6. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party may be required to pay are not covered, except as provided for in the provisions relating to Third Party Liability in the Coordination of Benefits Article. Those provisions explain the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies. Expenses (past, present or future) for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered.
7. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical program; or after the date the patient's coverage ends.
8. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental, Investigational and/or Unproven as defined in the Definitions Article of this document.
9. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.
10. **Military service related injury/illness**: If a covered individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

11. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence, or the commission or attempted commission of an assault or felony, is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
12. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if a Covered Individual leaves the facility against the medical advice of the attending Physician within 72 hours after admission.
13. **Medical Students, Interns or Residents:** Expenses for the services of a medical student, intern or resident.
14. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be medically necessary as defined in the Definitions Article of this document, except for certain wellness benefits as outlined in the applicable Schedule of Medical Benefits.
15. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.
16. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
17. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by a Covered Individual or their Covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if the individuals were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified.
18. **Personal Comfort Items:** Expenses for patient convenience, comfort, hygiene, or beautification, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, DVD/CD or similar device, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
19. **Physical Examinations, Tests for Employment, School, etc.:** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party.
20. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.
21. **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, Spouse, sibling (by birth or marriage) or child of the patient or covered Employee.
22. **Services Not Prescribed by a Physician or Health Care Practitioner**: Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, except for covered services provided by a Behavioral Health Practitioner, Audiologist, Chiropractor, Dentist, Midwife or Nurse Midwife, Nurse Practitioner, Physician Assistant, Podiatrist, or Health Care Practitioner acting within the scope of his/her license.
23. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions Article of this document.
24. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.
25. **Travel and Related Expenses:** Except for travel expenses associated with transplant surgery at certain in-network facilities, expenses for and related to travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual, unless those expenses have been pre-approved by the Plan Administrator or its designee.
26. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.

27. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, invasion, or release of nuclear energy, except as required by law.

28. **Failure to Provide Required Information:** If the Plan requests information from a Covered Individual in order to process a claim for benefits and that requested information is not provided within the timeframe allowed under the Plan, no payment will be extended for the questionable services. If the requested information is later received by the Plan in a timely manner according to the Claim Filing and Appeal Information Article of this document, the claim will be reviewed.

29. Expenses for and related to **Service animals**, including an animal that has been individually trained to do work or perform tasks for the benefit of an individual with a disability, such as seeing eye dogs, or other disability-assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. The Plan also excludes service animal supplies, transportation and veterinary expenses.

30. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.

31. **Untimely Filed Claims**: Expenses for services or supplies that would otherwise be covered by the Plan will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within 12 months from the date that the service is rendered or the supply provided.

32. Services provided to a Medicare enrollee for which the patient has entered into a **private contract that exempts the Health Care Practitioner from the Medicare** constraints or charges.

33. Expenses for individuals who perform services as a **scribe for electronic health records** (EHR), including electronic documentation and related services.

34. **Outpatient Pain Management Services obtained from non-PPO providers**: Expenses for outpatient pain management services, including treatment for chronic pain, are not covered when obtained from a non-PPO provider.

35. **Internet/Virtual Office/Telemedicine Services**: Expenses related to a non-network/non-contracted online internet consultation with a Non-Network Physician or other Health Care Practitioner, also called a virtual office visit/consultation, web visit, Physician-patient web service or Physician-patient e-mail service, telemedicine (real time or store and forward types), telehealth, e-health, e-visit, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider. See the Quick Reference Chart for information on the covered virtual visit service.*

    *NOTE: Effective March 1, 2020 and through the end of the Emergency Period during which the federal government has announced a National Emergency due to COVID-19, telephone calls and virtual visits for covered services performed by in-network providers outside of the Plan's exclusive Telemedicine Services Provider are payable. Such services are subject to the copayment and coinsurance provisions of the Plan, on the same basis as a face-to-face visit.

Exclusions Applicable To Specific Medical Services and Supplies.

1. **Alternative/Complementary Health Care Services Exclusions**

    a. Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

    b. Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner.

    c. Expenses for naturopathic, naprapathic and/or homeopathic supplies.

2. **Behavioral Health Care Exclusions**

    a. Expenses for hypnosis, hypnotherapy and/or biofeedback.

    b. Expenses related to enuresis (bedwetting).

    c. Expenses for Behavioral Health Care services related to:

        1) dyslexia, learning disorders, educational delays, including tests and related expenses to determine the presence of or degree of a person's dyslexia or learning/reading disorder.

        2) vocational disabilities;

3) custody counseling;

4) family planning/pregnancy/adoption counseling;

5) marital or family counseling.

6) custodial care, defined as any services, supplies, care, or treatment rendered to a beneficiary/member who:
   a) is disabled mentally or physically as a result of a DSM-V-TR (or ICD-9, ICD-10 or most current version of the DSM Manual) mental health/substance abuse diagnosis, and such disability is expected to continue and be prolonged, and
   b) requires a protected, monitored or controlled environment whether inpatient, outpatient, or at home, and
   c) requires assistance with activities of daily living, and
   d) is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the beneficiary to function outside the protected, monitored or controlled environment.

7) testing, evaluation, consultation, therapy, services, supplies, or treatment for **personal or professional growth** and development

8) Services, supplies or treatment for or related to education or training for **professional licensure, certification, registration, accreditation.**

9) testing, evaluation, consultation, therapy, services, supplies, or treatment **relating to employment**, regardless of whether investigational or pre- or post-employment.

10) testing, therapy, service, supply, or treatment which **does not meet national standards** for mental health professional practice, or which have **not been found to be efficacious or beneficial** by one or more of the plans or its designees or authorized management entity's clinical quality or review committees based on a review of peer reviewed literature and clinical information available.

11) **experimental or investigative** testing, therapy, service, supply, or treatment, defined as an unproven therapy or treatment which may or may not be superior to a current 'gold standard' therapy and that meets one or more of the following criteria:
   a) Not generally accepted by the medical community as effective and proven
   b) Not recognized by professional medical organizations as conforming to accepted medical practice
   c) Not approved by the FDA or other requisite government body
   d) In clinical trials or need further study
   e) Rarely used, novel, or unknown and lack authoritative evidence of safety and efficacy.

12) **court ordered** psychiatric or substance abuse evaluation, treatment, and testing except when the plan or its designee determines that such services are medically necessary for the treatment of a DSM-IV mental health diagnosis according to established clinical criteria and clinical policies of the plan or its designee.

13) **psychological testing**, except when medically necessary as determined by the plan or its designee. Certification is made for tests that are medically necessary for diagnosing and/or treating a DSM-IV mental health diagnosis or for consultation and evaluation of psychological aspects of a medical condition. In most inpatient network facilities, psychological testing is part of the per diem and does not require pre-certification. For network facilities, where it is not included in the per diem or for non-network facilities, pre-certification is required. Certification is made for tests that are medically necessary for diagnosing and/or treating a DSM-IV mental health diagnosis or for consultation and evaluation of psychological aspects of a medical condition. Psychological and neuropsychological testing are considered in in the Behavioral Health Program administrator's clinical criteria when pre-certification is performed by that administrator.

14) any **non-prescription or over-the-counter drug,** supplement, or other medicinal treatment, unless required by the Affordable Care Act.

15) testing, therapy, service, supply, or treatment for conditions that are identified by the DSM-IV as **not being attributable to a mental disorder** but are additional conditions that may be a focus of clinical attention (i.e. V-Codes).

16) testing, therapy, service, supply, or treatment of organic disorders, dementia, and primary neurologic/ neurodevelopment/neurocognitive disorders, except for associated treatable and acute behavioral manifestations. Treatment of associated treatable psychiatric and acute behavioral manifestations or symptoms of these organic/developmental disorders if medically necessary pursuant to the plan's or its designee's clinical criteria may be considered in pre-certification review.

17) **Telephone Calls**: Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, review firm, or any representative of the Plan for any purpose whatsoever,

including, without limitation: communication with any representative of the Plan or its review firm for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members. *

18) **Internet/Virtual Office/Telemedicine Services:** Expenses related to a non-network/non-contracted online internet consultation with a Non-Network Physician or other Health Care Practitioner, also called a virtual office visit/consultation, web visit, Physician-patient web service or Physician-patient e-mail service, telemedicine (real time or store and forward types), telehealth, e-health, e-visit, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider. See the Quick Reference Chart for information on the covered virtual visit service.*

    *NOTE: Effective March 1, 2020 and through the end of the Emergency Period during which the federal government has announced a National Emergency due to COVID-19, telephone calls and virtual visits for covered services performed by in-network providers outside of the Plan's exclusive Telemedicine Services Provider are payable. Such services are subject to the copayment and coinsurance provisions of the Plan, on the same basis as a face-to-face visit.

19) any testing, therapy, service, supply, or treatment provided as a result of any **Worker's Compensation law** or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof (exclusive of Med-Cal/Medicaid) or caused by the conduct or omission of a third party for which the member/enrollee has a claim of damages or relief, unless the member/enrollee provides the plan or its designee with a lien against such claim for damages or relief in a form and manner satisfactory to the plan and its designee. Claims for conditions that are a result of a work related incident should always be submitted to the Worker's Compensation carrier for consideration first. Designees of the plan administering mental health or substance abuse covered services do not authorize treatment for conditions resulting from a work-related incident.

20) testing, evaluation, consultation, therapy, services, supplies, or treatment **provided by the beneficiary's parent, siblings, children**, current or former spouse.

3. **Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions**

   a. Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions Article of this document, including but not limited to air purifiers, air conditioners, swimming pools, spa/whirlpools, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, and water beds.

   b. Expenses for **replacement of lost, missing, or stolen**, **duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.

   c. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.

   d. Expenses for **occupational therapy adaptive supplies and devices** used to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.

   e. Expenses for **nondurable supplies,** except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

4. **Cosmetic Services Exclusions**

   a. No coverage for surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation/breast reduction except as otherwise covered, elimination of redundant skin of the abdomen or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

   b. The Medical Program **does** cover medically necessary Reconstructive Services following a surgery-related to a malignancy and reconstruction after a mastectomy. To determine the extent of this coverage, Covered Individuals should review Reconstructive Services in the applicable Schedule of Medical Benefits. Reconstructive surgery is payable for surgery that is necessary for the repair or alleviation of damage predominately caused by accidental bodily injuries precipitated by external means. Expenses are also considered payable for surgery that is necessary because of congenital disease or anomaly of a Dependent Child that has resulted in a functional defect. Non-functional defects resulting from congenital malformations of a Dependent Child will be considered on a case by case basis when determined by the Board of Trustees

or their designated agent that such surgery is medically indicated based upon the recommendation of a Physician or Health Care Practitioner designated by the Board of Trustees.

5. **Custodial Care Exclusions**

   a. Expenses for Custodial Care as defined in the Definitions Article of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, except when Custodial Care is provided as part of a covered Hospice program or is provided during a covered hospitalization, or when the services of certified nurse aides are payable under Home Health Care Services as described in the applicable Schedule of Medical Benefits.

   b. Any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are medically necessary.

6. **Dental Services Exclusions**

   a. Expenses for Dental services or supplies of any kind, (even if they are necessary because of symptoms, congenital anomaly or illness affecting the mouth or another part of the body) including but not limited to dental prosthetics, splints, retainers, oral appliances, orthodontia services and dental services for the care, filling, removal or replacement of teeth, or disease of the teeth, gums or structures directly supporting or attached to the teeth. No coverage for expenses for dental services such as removal of teeth including wisdom teeth, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement), root canal (endodontic) therapy. (Under certain circumstances the Medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Utilization Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the associated dental professional fee services provided while at a hospital or outpatient surgery facility as those fees would be paid by the patient's Dental Plan coverage. See the Schedule of Medical Benefits.)

   b. Expenses for Dental services may be covered under the Medical Plan if they are incurred for the repair or replacement of Accidental Injury to Teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. Any covered Oral and Craniofacial Services are described in the applicable Schedule of Medical Benefits.

   c. Expenses for Orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with Prognathism, Retrognathism, or other cosmetic reasons.

   d. Treatment for Temporomandibular Joint dysfunction/syndrome.

7. **Drugs, Medicines and Nutrition Exclusions**

   a. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (*i.e.* are used "off-label"). Off-label use of an FDA approved drug will only be considered for payment (as not being experimental or investigational), on a case by case basis considering the facts and circumstances of the clinical situation, if approved by the Board of Trustees with medical evidence to support the fact that the benefits of the use of the drug outweigh the risks, or the off label use of an FDA drug relates to treatment of cancer. The Board of Trustees reserves the right to seek independent medical review regarding the request for off label drug use.

   b. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin, and drugs mandated for coverage in accordance with Affordable Care Act regulations.

   c. Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, dietary supplements, vitamins, herbs and minerals, enzymes (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization or as mandated for coverage in accordance with Affordable Care Act regulations.

      Nutritional support may be payable when it is determined by the Plan Administrator or its designee to be Medically Necessary, and is the sole means of adequate nutritional intake and is administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration) and is not considered a food thickener, infant formula, donor breast milk, baby food, or other non-prescription product that can be mixed in a blender.

   d. Naturopathic, naprapathic or homeopathic substances.

e. Drugs, medicines or devices for:

i. contraceptives drugs and devices for males;

ii. hair removal or hair growth products (*e.g.,* Propecia, Rogaine, Minoxidil, Vaniqa);

iii. erectile dysfunction (*e.g.,* Viagra, Cialis, Muse, Caverject);

iv. drug treatment of female hypoactive sexual desire disorder (HSDD) (e.g. Addyi);

v. vitamin A derivatives (retinoids) for dermatologic use (*e.g.* Retin A, Renova) are excluded after age 26;

vi. appetite suppressants or anorexiants (*e.g.,* Xenical), except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.

f. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.

g. Self-help devices such as a scale, pill crusher, magnifying glass/device, etc.

h. This Plan has adopted the Prescription Drug Program's current formulary, including its preferred drug list, as the Plan's covered formulary of covered drugs. Based on the Prescription Drug Program's formulary (which is updated from time to time), certain drugs are not covered by the Plan, or are covered only when they are pre-approved by the Prescription Drug Program. Contact the Prescription Drug Program for information about the formulary or Drug Exception Process.

Drug Exception Process: The Plan has an exception process managed by the Prescription Drug Manager (whose contact information is listed on the Quick Reference Chart in the front of this document). The exception process allows a member's physician or Health Care Practitioner to contact the Prescription Drug Manager to request that a non-covered drug be payable under the Plan. The physician or Health Care Practitioner is to fax the request for a drug exception and the clinical reasons why the drug is needed, including why a formulary (Preferred drug) cannot be used in its place, to the clinical team of the Prescription Drug Manager who will review and respond to the physician or Health Care Practitioner with their determination.

i. Certain covered drugs are not filled or administered through the Prescription Drug Program, such as intrathecal administration of a class of drugs called "survival motor neuron-2 (SMN2)-directed antisense oligonucleotides," which includes drugs such as Spinraza (nusinersen). Covered drugs not filled or administered through the Prescription Drug Program may be submitted for payment to the Medical Plan Claim Administrator.

8. **Durable Medical Equipment Exclusions**

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

9. **Fertility and Infertility Services Exclusions**

a. Expenses for surrogate parenting or surrogate related expenses (surrogate refers to an arrangement for a woman to carry and give birth to a child who will be raised, and usually legally adopted, by others and often includes invitro fertilization, the implantation of a fertilized egg for the purpose of carrying the fetus to term for another woman) including expenses for and related to the pregnancy, delivery fees and complications for the woman who is the surrogate; cryostorage of egg or sperm (longer than one year), adoption, and reversal of sterilization procedures.

10. **Foot/Hand Care Exclusions**

a. Expenses for routine foot care, (routine foot care includes but is not limited to hygienic cleaning of the feet trimming of toenails, removal or reduction of corns and callouses, removal thick/cracked skin on heels, foot massage, preventive care with assessment of pulses, skin condition and sensation) or hand care including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury or symptoms involving the hand, unless the Plan Administrator or its designee determines such care to be medically necessary. Medical treatment of the foot, by a podiatrist, is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

b. Expenses for weak or fallen arches, flat or pronated foot metatarsalgia or foot strain, orthopedic shoes, certain foot orthotics and supportive devices for the feet such as arch supports, heel lifts, strapping or similar items, unless the orthotic is listed as payable under the Corrective Appliances row of the Schedule of Medical Benefits in this document.

11. **Genetic Testing and Counseling Exclusions**

a. **Genetic Testing:** Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, except as listed as payable in the Genetic Testing row in the Schedule of Medical Benefits and as required under the Affordable Care Act. Non-covered genetic services includes:

i. **Pre-parental genetic testing (also called carrier testing)** intended to determine if an individual is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected children.

No coverage for pre-parental/carrier genetic testing intended to determine if a prospective parent or parents or in vitro embryo have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents;

ii. **Prenatal genetic testing** intended to determine if a developing fetus is a risk for inheriting identifiable genetic diseases or traits **except** as described in the Genetic Testing row of the Schedule of Medical Benefits that covers tests using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women;

iii. **Genetic testing and non-covered individuals:** No coverage of genetic testing of Covered Individual if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the treatment of a Covered Individual.

iv. **Home genetic testing kits/services** are not covered.

v. Genetic testing determined by the Plan Administrator or its designee to be **not medically necessary or is determined to be experimental or investigational**.

Any Genetic Services covered by the Plan will be specified in the applicable Schedule of Medical Benefits. Plan Participants can contact the Medical Plan Claims Administrator for assistance in determining if a proposed Genetic Test will be covered or excluded.

b. **Genetic Counseling:** Except as required under the Affordable Care Act, expenses for genetic counseling are not covered, unless these three conditions are met: is ordered by a Physician or Health Care Practitioner, performed by a qualified genetic counselor and performed in conjunction with a genetic test that is payable by this Plan.

12. **Hair Exclusions**

a. Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis.

13. **Home Health Care Exclusions**

a. Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies, except when the services of Home Health aides are payable under Home Health Care Services in the schedule of Medical Benefits.

b. Expenses under a Home Health Care program for services that are provided by someone who is not acting under the scope of his/her license and who ordinarily lives in the patient's home or is a parent, Spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician or Health Care Practitioner.

c. Expenses for a homemaker, custodial care, child care, adult care or personal care attendant, except as provided under the Plan's Hospice coverage, and when custodial care is provided by Home Health aides that are payable under Home Health Care Services in the Schedule of Medical Benefits.

14. **Hearing Care Exclusions**

a. Expenses for hearing aid batteries and other hearing aid accessories including Dri-Aid kits for hearing aid moisture removal and phone pads.

15. **Maternity/Family Planning/Contraceptive Exclusions**

a. **Contraception:** Expenses related to contraceptive drugs and devices for males, such as condoms.

b. Expenses for **childbirth education, and Lamaze classes**.

c. Expenses related to the **maternity care and delivery expenses associated with a surrogate mother's pregnancy.**

d. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**

e. No coverage is provided for the **baby of a Dependent Child**. Pregnancy-related care is covered for a female Covered Individual (see the Maternity row of the Schedule of Medical Benefits).

16. **Rehabilitation Therapy Exclusions (Inpatient or Outpatient)**

a. Expenses for educational, job training, vocational rehabilitation, or recreational therapy.

b. Expenses for massage therapy, rolfing (deep muscle manipulation and massage), craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas) and related services.

c. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise

incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and services.

d. Expenses for Maintenance Rehabilitation as defined under Rehabilitation in the Definitions Article of this document.

e. Expenses for speech therapy for functional purposes including, but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering and conditions of psychoneurotic origin.

f. Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired).

17. **Transplant (Organ and Tissue) Exclusions**

a. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications thereof, except those Transplant Services and their complications that are listed as payable under Transplantation in the Schedule of Medical Benefits.

b. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.

c. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except heart valves, kidney dialysis, and a ventricular assist device (VAD) (that is a mechanical pump used to assist a damaged or weakened heart in pumping blood) only when used as a bridge to a heart transplant or for support of blood circulation post-cardiotomy (following open-heart surgery, or for destination therapy (permanent mechanical cardiac support only if there is approval from the FDA for that purpose, and the device is used according to the FDA-approved instructions).

d. Donor expenses unless the person who receives the donated organ/tissue is a person covered by this Plan.

18. **Vision Care Exclusions**

a. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK).

b. Expenses for diagnosis and treatment of refractive errors, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except as provided by the vision exam benefit in the Vision PPO Plan, described in Article 9.

c. Vision therapy (orthoptics) and supplies.

19. **Weight Management and Physical Fitness Exclusions**

a. Expenses for weight loss drugs and surgical treatment of obesity that does not meet the Weight Management benefit of the Plan described in the applicable Schedule of Medical Benefits. This exclusion does not apply to the extent that it constitutes screening and counseling for obesity or otherwise qualifies under the Wellness and Preventive Services row of the Schedule of Medical Benefits.

b. Skin reduction procedures/treatment following excessive weight loss.

c. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services, expenses for a masseur, physical culturist, physical education instructor, swimming program/sessions, or exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers.

ARTICLE 8: DENTAL PPO PLAN BENEFITS

Dental PPO Plan Benefits Overview.

1. All employees and their eligible dependents may participate in this Dental PPO Plan. Dental benefits are effective on the date your medical plan benefits are effective.

   Dental PPO Plan benefits are designed to constitute and to be administered as "excepted benefits," as defined by federal law.

2. **You have the option to decline Dental Plan coverage**: In accordance with Affordable Care Act regulations, you have the option to decline the Plan's dental coverage. To decline coverage, complete the portion of the Plan's enrollment form related to declining dental plan coverage. Enrollment forms are available from the Administrative Office. If you decline dental coverage you may re-enroll for such coverage after 12 months has lapsed by contacting the Administrative Office.

3. Not every dental care service or supply is covered by the Dental Plan, even if prescribed, recommended, or approved by your physician or dentist. The Plan covers only those services and supplies that are medically necessary and included as a covered benefit under this Dental Plan. The Plan will not reimburse any expenses that are not eligible dental expenses. That means you will be responsible for paying the full cost of all expenses that are determined to be medically unnecessary, determined to be in excess of the Allowed Charges, not covered by the Dental Plan, or are in excess of a maximum Dental Plan benefit.

Dental Network.

1. The Dental PPO Plan contracts with a network of dental providers (e.g. dentists and dental hygienists) who extend a discount to you for covered dental services. Covered expenses are noted in the Schedule of Dental Benefits in this Article and refer to the Allowed Charge for covered services up to the maximum allowed as payable under this Dental PPO Plan.

2. **Network Providers:** In-Network providers (licensed dentists and dental hygienists) have a contract with the Dental network to provide discounted fees to you for services covered under this Dental Plan. By using the services of an In-Network provider, both you and the Plan pay less. A current list of network dental providers is available free of charge when you contact the Dental Plan Network whose name, telephone number and website are listed on the Quick Reference Chart in the front of this document. For a paper copy of the provider directory, at no charge, contact the Dental Plan as listed on the Quick Reference Chart in the front of this document. To receive services, simply call a network dental provider and identify yourself as a member of this Dental Plan.

3. **Non-Network (Out-of-Network) Providers:** Services may be received from any licensed dental provider; however, this Plan will pay at the Non-Network benefit level as noted in the Schedule of Dental Benefits. The itemized bill reflecting the Non-Network provider's fees must be submitted to the Dental Plan Claims Administrator for reimbursement. You will be reimbursed according to the Allowed Charge amount.

   Non-Network provider services may cost you more than if those same services were obtained from an In-Network provider. **Non-Network Providers may bill the Plan participant for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called balance billing.** Balance billing occurs when a provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. **You can avoid balance billing by using In-Network providers.** (See the definitions of Allowed Charge and Balance Billing in the Definitions Article of this document.)

Covered Dental Expenses.

1. You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider that are determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that:
   a) the Plan Administrator or its designee determines that the services are the most cost-effective ones that meet acceptable standards of professional dental practice and would produce a satisfactory result; **and**
   b) services are not **experimental or investigational; and**
   c) **services or supplies are not excluded** from coverage (see the Dental Plan Exclusions in this Article); and
   d) **services or supplies are not in excess** of a Maximum Plan Benefit as shown in this Article; and
   e) the charges for dental services are **"**Allowed Charge**."** See the Definitions Article under "Allowed Charge."

2. The Plan will not reimburse you for any expenses that are not Eligible Dental Expenses. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Dental Expenses that exceed the amount determined by the Plan to be Allowed Charge.

3. Coinsurance is how you and the Plan will split the cost of certain covered dental expenses. The Plan pays a percentage of the Eligible Dental Expenses, and you are responsible for paying the rest. The applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits. The part you pay is called the Coinsurance.

4. Covered Dental Expenses shall include Allowed Charges for necessary dental care and treatment of disease, defect or accidental injury, or for preventive dental care as prescribed by a Dentist or Physician, as noted in the Schedule of Dental Benefits.

5. In all cases in which the Covered Individual selects a more expensive plan of treatment than is customarily provided, the Dental Plan will pay the applicable percentage of the lesser fee. The Covered Individual is responsible for the remainder of the Dentist's fee.

6. **Annual Maximum Dental Plan Benefits:** The Plan's annual maximum dental plan benefit per calendar year is listed on the Schedule of Dental Benefits.

Payment Of Dental Benefits.

Dental services and supplies are **considered to have been incurred on the date the services are performed or supplies are furnished**. Completion of dental services is required for payment by this Plan. The Plan will consider partial payment of benefits as follows:

a) **Fixed Partial Dentures, Bridgework, Crowns, Inlays and Onlays:** All services related to installation of Fixed Partial Dentures, Bridgework, Crowns, Inlays and Onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) installed.

b) **Removable Partial or Complete Dentures:** All services related to the preparation of Removable Partial or Complete Dentures are considered to have been incurred on the date the impression for the Dentures is taken.

c) **Root Canal Treatment (Endodontics):** All services related to Root Canal treatment (Endodontics) are considered to have been incurred on the date the tooth is opened for the treatment.

d) **Orthodontia:** Services related to Orthodontia are provided over a period of many months, and are usually subject to a fixed charge for the entire program of treatment, usually payable in monthly installments. All services related to Orthodontia are considered to have been incurred on a month-to-month basis, and the Plan will pay benefits for services performed each month as long as eligibility for dental benefits is maintained, active treatment is continued and the benefit maximum has not been reached.

Alternative Procedures.

Often there are several ways to treat a particular dental problem that will produce a satisfactory result. The Plan will pay benefits based on the procedure that meets the **least expensive professionally acceptable** standards of dental practice in the U. S. as determined by the Dental Plan Claims Administrator. You may choose a more costly procedure. However, if you do, you will be responsible for paying the difference between the charges for the more costly procedure and the benefits paid by the Plan. **All treatment decisions rest with you and your Dentist.** The pretreatment estimate procedure described below will help you know what benefits the Plan will pay. You will then be able to determine the difference (if any) that you may have to pay yourself.

Pretreatment Estimate (Predetermination Of Benefits).

Whenever you expect that your dental expenses for a course of treatment will be **more than $300**, you may use the voluntary pretreatment estimate procedure. This procedure lets you know how much you will have to pay before you begin treatment.

To obtain a pretreatment estimate, you and your Dentist should complete the regular dental claim form, available from and to be sent to the Dental Plan Claims Administrator indicating the type of work to be performed along with pertinent x-rays, diagnostic materials and the estimated cost. Once it is received, the Dental Plan Claims Administrator will review the form and then send you and your Dentist (within 30 days) a statement showing what the Plan will pay. Your Dentist may call the Dental Plan Claims Administrator, whose number is listed on the Quick Reference Chart in the front of this document, for a prompt determination of the benefits payable for a particular dental procedure. If there is a change in the treatment plan, a revised plan should be submitted.

Predetermination of benefits is not a guarantee of payment. Payment is based on the services actually delivered and the coverage in force at the time services are completed.

Precertification of Certain Dental Services.

Dental implants and implant-related codes (such as abutments) require precertification (pre-approval) by the Dental PPO Plan Claims Administrator or else there is no payment by the Plan. Contact information for the Dental PPO Plan Claims Administrator is listed on the Quick Reference Chart in the front of this document.

Prescription Drugs Needed For Dental Purpose.

Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications prescribed by a Physician or Dentist, should be obtained using the Prescription Drug Benefit of the Medical Plan.

Extension of Dental Benefits.

1. If dental coverage ends for any reason, the Plan will pay Plan benefits for you or your covered Dependents until the end of the month in which the coverage ends. The Plan will also pay benefits for a limited time beyond that date for the following:
   a) Expenses for root canals, crowns, fixed bridges, partial and dentures will be covered after loss of eligibility for up to 30 days, provided the service was actually started before loss of eligibility.
   b) "Started" means that, with a root canal, the tooth was opened; with a crown or bridgework, that the teeth were prepared and impressions were taken; and with partials and dentures, that final impressions were taken.
2. In addition, services that have been pre-approved by the Dental Plan Claims Administrator, as part of its predetermination mechanism at a time at which the individual was eligible, will be covered for the period indicated on the Predetermination Voucher forwarded to the Dentist, unless the individual is no longer eligible under the Plan. Other services provided after loss of eligibility will not be covered.

Coordination of Benefits for Dental Benefits.

Coordination of Benefits or COB takes place when a person is entitled to benefits from more than one dental plan. The dental plans will coordinate the benefits to eliminate duplication of benefits. Coordination of Benefits (COB) for this Dental Plan is administered as a Maintenance of Benefits design. Maintenance of benefits (MOB) reduces covered dental charges by the amount the primary plan has paid, and then applies this Plan's Dental plan deductible and coinsurance. See also the Coordination of Benefits Article for more information.

Schedule Of Dental Benefits.

1. A chart outlining a description of the Dental PPO Plan Benefits and the explanations of them plus the difference in payment if an In-network or Non-network dental provider is used, appears on the following pages.

SCHEDULE OF DENTAL BENEFITS

See the Dental PPO Plan Exclusions and Definitions Articles of this document for important information.
If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Provider	Non-Network Provider
Dental Plan Deductible		None	None
Annual Dental Plan Maximum Benefit	• No annual dental maximum for in-network services. • Annual maximum for non-network dental services is $2,500 per person per calendar year (not including orthodontia).	None	$2,500 per person per calendar year

SCHEDULE OF DENTAL BENEFITS

See the Dental PPO Plan Exclusions and Definitions Articles of this document for important information.
If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Provider	Non-Network Provider
Type A Dental Services **(Routine, Diagnostic and Preventive)** **Diagnostic:** The necessary procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment. **Preventive:** The necessary procedures to prevent the occurrence of oral disease. • Oral examination. • Prophylaxis (cleaning of the teeth). • Problem focused examination in connection with emergency palliative treatment or consultation purposes. • Full mouth x-rays. • Bitewing x-rays. • Vertical bitewing x-rays. • Panoramic x-rays. • Topical application of sodium or stannous fluoride.	• Routine oral examinations are payable twice every calendar year. Problem focused examinations have no frequency limitation. • Two cleanings and periodontal maintenance have a combined frequency payable twice every calendar year. • Two sets of bitewing x-rays are payable per calendar year. • One set of full mouth x-rays or panoramic x-ray payable every three rolling years. • One set of vertical bitewing x-rays payable every three rolling years. • Panoramic x-ray payable every three rolling years. • Two fluoride treatments are payable every calendar year for children through the calendar year of their 15th birthday.	No charge	Plan pays 80% of the Allowed Charge, as determined by the Dental Plan Claims Administrator
Type B Dental Services **(Basic Dental Services)** • Application of sealants on posterior permanent teeth (molars). Sealants are topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay. • Periodontal maintenance prophylaxis. Periodontal scaling and root planning. • Emergency Services: benefits will be provided for emergency palliative care. • Simple tooth extractions • Fillings: Amalgam (silver), silicate, acrylic, synthetic porcelain (ceramic with natural tooth coloring) and composite resin (plastic compound with natural tooth coloring) filling restoration for decayed or broken teeth. • Endodontic treatment, including root canal therapy. Endodontics is the necessary procedures for pulpal therapy and root canal filling on infected teeth. • Denture adjustment or repair • Repair or re-cementing of crowns, inlays or onlays	• One sealant treatment every 36 months for children through the calendar year of their 14th birthday, on permanent first and second molars only. Sealants include the application of sealants only to permanent first and second molar teeth with no decay or existing restorations. Benefits are determined on a per tooth basis and not on a per surface application. Sealant benefit does not include the repair or replacement of a sealant on any tooth within three years of its application under any plan. • Periodontal scaling and root planning: 4 separate quadrants are payable per 12 months.	No charge	Plan pays 80% of the Allowed Charge, as determined by the Dental Plan Claims Administrator

SCHEDULE OF DENTAL BENEFITS

See the Dental PPO Plan Exclusions and Definitions Articles of this document for important information.
If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Provider	Non-Network Provider
Type C Dental Services **(Major Dental Services)** • Space maintainers. • Surgical extractions or impactions • Prosthodontics: The necessary procedures for construction of bridges, partial and complete dentures. Installation of fixed bridgework; full and partial dentures. • Inlays, onlays and crowns. • Oral surgery including pre- and post-operative care • General anesthesia and IV sedation. • Benefits will be provided for general anesthesia when Medically Necessary and administered in connection with covered oral surgery. • Gingivectomy • Restoration Dentistry with necessary procedures to provide amalgam, composite resin or plastic restorations for treatment of decay or fracture. • Periodontics: Necessary procedures for the treatment of the tissues supporting teeth. (Note that certain periodontal services like scaling and root planning and periodontal maintenance are Type B Basic services.) • Lab processed restorations. • Occlusal guards for bruxism.	• Full and partial dentures are payable. • Fixed bridgework, crowns, inlays and onlays are payable • Replacement of an existing denture only if it is unsatisfactory and cannot be made satisfactory, and was installed at least 5 years before its replacement. • Partial Dentures: The Fund will provide a standard chrome or acrylic partial denture, or will allow the cost of such procedure toward a more complicated or precision appliance that the Covered Individual and Dentist may choose to use. • Complete Dentures: If, in the construction of a denture, the Covered Individual and Dentist decide on personalized restorations or use specialized techniques as opposed to standard procedures, the Fund will allow an appropriate amount for the standard denture toward such treatment and the Covered Individual must bear the difference in cost. • The Fund will allow the cost of restorations required to replace missing teeth for dependent children to age 19. Restorations required to replace missing teeth for all other members will be subject to the guidelines of the missing and unreplaced exclusion. • Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the Covered Individual. Such procedures include, but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from wear (unless tooth is in imminent danger of pulpal death) and restoration for misalignment of the teeth.	80% of the network provider's discounted amount	Plan pays 80% of the Allowed Charge, as determined by the Dental Plan Claims Administrator
Additional Dental Services • Dental implants • Dental TMJ services	• **Dental implants and implant-related codes must be preauthorized in advance or no benefits will be paid**. Note: if results can be achieved under an alternate benefit the implant will be denied in its entirety. • Dental TMJ benefit for both adults and dependent children with no age limit. Covers appliance therapy and x-rays. Diagnostic materials including impressions are not covered.	Dental Implants and implant related codes: 80% of the network provider's discounted amount Dental TMJ covered at the orthodontic coinsurance level of 50% with no maximum	Dental Implants and implant related codes: 80% of the Allowed Charge, as determined by the Dental Plan Claims Administrator Dental TMJ covered at the orthodontic coinsurance level of 50% with no maximum

SCHEDULE OF DENTAL BENEFITS *See the Dental PPO Plan Exclusions and Definitions Articles of this document for important information.* If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**			
Benefit Description	**Explanations and Limitations**	**In-Network Provider**	**Non-Network Provider**
Orthodontia Services • Necessary services related to an active course of Orthodontia treatment including diagnosis, evaluation and pre-care. • The initial installation of Orthodontic appliances for an active course of Orthodontia treatment. • Adjustment of active Orthodontia appliances. • This Orthodontia benefit is for nonsurgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function. • Expenses related to Orthodontia will be covered only when one or more of the conditions shown to the right have been satisfied.	• Orthodontia benefits are available for dependent children to age 26 years. • Payment for Orthodontia benefits will not continue if treatment ceases for any reason. • Repair or replacement of Orthodontia appliances are not covered.	50% of the network provider's discounted amount	Plan pays 50% of the Allowed Charge, as determined by the Dental Plan Claims Administrator

Dental PPO Plan Exclusions.

The following is a list of dental services and supplies or expenses **not covered by the Dental PPO Plan**. The Plan Administrator, and Dental Plan Claims Administrator, to whom responsibility for the administration of the Dental Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

The Fund excludes those services that may be classified as:

1. Services for injuries or conditions which can be compensated under workers' compensation or employers' liability laws; services which are provided the Covered Individual by any federal or state government agency or are provided without cost to the Covered Individual by a municipality, county or other political subdivision or community agency.
2. Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and anodontia.
3. No coverage for crowns, inlays and onlays, and veneers unless: a) it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or b) the tooth is an abutment to a covered partial denture or fixed bridge.
4. Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).
5. General anesthesia, except when administered for a covered oral surgery procedure performed by a Dentist and when Medically Necessary. General anesthesia and intravenous sedation is not covered unless specifically listed as a covered benefit in the Schedule of Dental Benefits and only when done in connection with another necessary covered service or supply.
6. Prescription drugs, pre-medication, or analgesia.
7. Hypnosis.
8. Dietary instruction including instruction for plaque control and oral hygiene
9. Charges for Hospital services.
10. Myofunctional therapy.
11. Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for

psychological or emotional reasons; except to the extent coverage is specifically provided in the Schedule of Dental Benefits. Facings on molar crowns and pontics will always be considered cosmetic.

12. Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
13. First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered, unless five or more years have passed since the date of the most recent initial eligibility.
14. Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
15. Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
16. Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.
17. Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
18. Surgical removal of impacted wisdom teeth only for orthodontic reasons.
19. Treatment by other than a Dentist. However, the Plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a Dentist. These are: Scaling of teeth; Cleaning of teeth; and Topical application of fluoride.
20. **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, interest charges, late fees and/or photocopying fees.
21. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation, Annual Maximum Plan Benefits, or Overall ("Lifetime") Maximum Plan Benefits as described in the Dental PPO Plan Benefits Article.
22. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions Article of this document.
23. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to Third Party Liability in the Article on Coordination of Benefits.
24. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the dental program; or after the date the patient's coverage ends, except under those conditions described in the Extension of Dental Benefits in the Dental PPO Plan Benefits Article or under the COBRA provisions of the Plan.
25. **Experimental and/or Investigational Services:** Expenses for any dental services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions Article of this document.
26. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
27. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
28. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions Article of this document.
29. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.
30. **Education Services and Home Use Supplies:** Expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss, etc.

31. **Hospital Expenses Related to Dental Care:** Expenses for hospitalization or outpatient surgery facility services related to Dental surgery or care.
32. Expenses for and related to **cryostorage of peripheral stem cells in teeth or other tissue.**
33. All other services not specified as covered dental services.
34. Expenses related to a non-covered service including services and supplies provided in connection with treatment or care that is not covered under the Plan.

ARTICLE 9: VISION PPO PLAN BENEFITS

Vision Plan Benefits Overview.

1. All employees and their eligible dependents may participate in this Vision PPO Plan. Vision benefits are effective on the date your medical plan benefits are effective.
2. **You have the option to decline Vision Plan coverage**: In accordance with Affordable Care Act regulations, you have the option to decline the Plan's vision coverage. To decline coverage complete the portion of the Plan's enrollment form related to declining vision plan coverage. Enrollment forms are available from the Administrative Office. If you decline vision coverage you may re-enroll for such coverage after 12 months has lapsed by contacting the Administrative Office.
3. To facilitate the provision of routine eye exams and necessary corrective lenses the Plan has entered into an agreement with an independent vision PPO network and vision plan claims administrator (their contact information is listed on the Quick Reference Chart in the front of this document). Vision problems related to bodily illness and injury are covered under the Medical Plans offered by the Fund.
4. Participants who have elected the HMO Medical Plan option will have their vision benefits provided by and administered by the HMO Medical Plan in their geographic region.
5. The Vision Plan described in this document is a PPO vision plan that is designed to provide for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. The Vision Plan can detect individuals who have chronic diseases that can affect the eye such as diabetes, high blood pressure (hypertension), glaucoma, and cataracts.
6. Vision benefits are administered by an independent Vision Plan Claims Administrator whose name and address are listed on the Quick Reference Chart in the front of this document.
7. Vision benefits are designed to constitute and to be administered as "excepted benefits", as defined by federal law.

Vision Network.

1. The Vision PPO Plan contracts with a network of vision providers (e.g. optometrists, opticians) who extend a discount to you for covered vision services. Covered expenses are noted in the Schedule of Vision Benefits in this Article and refer to the Allowed Charge for covered services up to the maximum allowed as payable under this Vision PPO Plan.
2. **Network Providers:** In-Network providers (such as opticians and optometrists) have a contract with the Vision network to provide discounted fees to you for services covered under this Vision Plan. By using the services of an In-Network provider, both you and the Plan pay less. A current list of network vision providers is available free of charge when you contact the Vision Plan Network whose name, telephone number and website are listed on the Quick Reference Chart in the front of this document. For a paper copy of the provider directory, at no charge, contact the Vision Plan as listed on the Quick Reference Chart in the front of this document. To receive services, simply call a network vision provider and identify yourself as a member of this Vision Plan.
3. **Non-Network (Out-of-Network) Providers:** Services may be received from any qualified vision provider; however, this Plan will pay at the Non-Network benefit level as noted in the Schedule of Vision Benefits. The itemized bill reflecting the Non-Network provider's fees must be submitted to the Vision Plan Claims Administrator for reimbursement. You will be reimbursed according to the Allowed Charge amount.
4. Non-Network provider services may cost you more than if those same services were obtained from an In-Network provider. **Non-Network Providers may bill the Plan participant for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called balance billing.** Balance billing occurs when a provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. **You can avoid balance billing by using In-Network providers.** (See the definitions of Allowed Charge and Balance Billing in the Definitions Article of this document.)

Covered Vision Expenses.

1. Under this Vision PPO Plan, you are covered for expenses you incur for many, but not all, vision services and supplies provided by a Vision Care Provider that are determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that:
   a) the Plan Administrator or its designee determines that the services are the most cost-effective ones that meet acceptable standards of professional vision practice and would produce a satisfactory result; **and**
   b) services are not **experimental or investigational; and**
   c) **services or supplies are not excluded** from coverage (as provided in the Vision Exclusions); **and**

d) **services or supplies are not in excess** of a Maximum Plan Benefit as shown in this Article; **and**

e) the charges for vision services are "Allowed Charge." See the Definitions Article under "Allowed Charge."

2. The Plan will not reimburse you for any expenses that are not Eligible Vision Expenses. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Vision Expenses that exceed the amount determined by the Plan to be Allowed Charge.

3. All benefits are described in the Schedule of Vision Benefits. The Fund will make network materials available to Covered Individuals.

4. If a Covered Individual incurs expense for an **eye refraction** performed by a Doctor of Medicine or Optometry, the Plan will pay for an **eye examination** as outlined in the Schedule of Vision Benefits.

5. If a Covered Individual incurs expense for **lenses** supplied by an Optometrist or Optician (including expenses for **contact lenses)** the Plan will pay for **lenses** as outlined in the Schedule of Vision Benefits.

6. If a Covered Individual incurs expenses for **frames** supplied by an Optometrist or Optician, the Fund will pay for **frames** as outlined in the Schedule of Vision Benefits.

Definition Of Terms Related To This Vision Plan.

1. A **vision exam** includes a professional eye examination and an eye refraction (a refraction billed without an exam is not covered). The exam typically includes:
   a) an assessment of your health history that is relevant to your vision,
   b) external exam of the eyes for pathological abnormalities of the eyes including but not limited to the pupil, lens, eyelashes and eyelids,
   c) internal exam including but not limited to an assessment of the lens and retina along with tononometry (measurement of the fluid pressure in the eye to help detect signs of glaucoma), visual field testing (checks peripheral visual capabilities), biomicroscopy (retina examination) and inspection of the retina with an ophthalmoscope, visual acuity (the ability to see clearly at all distances) and refraction (testing the eyes' ability to focus light rays on the retina from a distance and close-up).

2. **Contact lens exam** includes the comprehensive exam covered under the exam benefit along with the assessment of the optical and physical characteristics of the eye and the surface of the eye such as power, size, curvature, flexibility, gas-permeability, moisture/tear content, along with prescription of contact lens, fitting, evaluation, modification and dispensing of the contacts. Contact lens services may be provided by a doctor or optician. Contact lens exams are designed to ensure the proper fit of contacts and to evaluate vision with the contacts. Although the vision may be clear and a person may feel no discomfort from their lenses, there are potential risks with improper wearing or fitting of contact lenses that can affect the overall health of the eyes. The regular "vision exam" does not include a contact lens exam. A contact lens exam is in addition to a regular eye exam.

3. **Optician** means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.

4. **Optometrist** is a person licensed to practice optometry. Optometrists examine the internal and external structure of the eyes to diagnose eye diseases like glaucoma, cataracts and retinal disorders; systemic diseases like hypertension and diabetes; and vision conditions like nearsightedness, farsightedness, astigmatism and presbyopia.

5. **Ophthalmologist** is a Physician (MD or DO) licensed to practice ophthalmology, including eye surgery and prescription of drugs.

6. **Lenticular lens (Vision):** a vision lens of high diopter power with the prescription ground only into the central portion of the lens while the periphery of the lens usually does not contain any power and serves only to give dimensions suitable for mounting in a frame. The lenticular lens design helps reduce the thickness of the lens, making it lighter weight and more cosmetically and functionally appealing.

7. **Photochromic lenses:** lenses change from clear indoors to sunglass dark outdoors according to intensity of sunlight.

Extension of Vision Benefits.

1. If service for a Covered Individual is being rendered at the time his/her coverage hereunder terminates, Vision Care Expense Benefits will continue to be paid for such services, but not beyond 1 month after termination of coverage.

Schedule Of Vision Benefits.

1. A chart outlining a description of the Vision PPO Plan Benefits and the explanations of them plus the difference in payment if an In-network or Non-network vision provider is used, appears on the following pages.

SCHEDULE OF VISION BENEFITS

See the Vision PPO Plan Exclusions and the Definitions Article of this document for important information.
If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits.
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**

Covered Vision Benefits	Explanations and Limitations	Plan Pays	
		In-Network Provider	Non-Network Provider
Vision Examination *without* contact lens fitting.	• One annual vision exam (with eye refraction) for Active Employees and their covered Dependents is payable per calendar year. • Benefits are payable when the vision exam is performed by any licensed vision provider, such as an optometrist or ophthalmologist.	**Eye Exam:** 100% after $10 copay.	After a $10 copay, the Plan pays 100%, to a maximum of $40.
Frames for Eyeglasses	• Benefits for one pair of frames are payable once every calendar year. • Frame allowance may be applied toward non-prescription sunglasses for post PRK, LASIK or custom LASIK patients.	**Frames:** 100% to a maximum of $90 retail value; 20% discount on amount over allowance.	The Plan pays 100% to a maximum of $30.
Lenses for Eyeglasses	• ~~A~~ One pair of single vision, lined bifocal, lined trifocal, lined lenticular or progressive lenses is payable once every calendar year. • Photochromic lenses (tinted Pink #1 or Pink #2) covered at 100%, in-network.	**Single Vision Lenses:** 100% **Lined Bifocal Lenses:** 100% **Lined Trifocal Lenses:** 100% **Lenticular Lenses:** 100%	The Plan pays: **Single Vision Lenses:** 100%, up to $30. **Lined Bifocals Lenses:** 100%, up to $40. **Lined Trifocals Lenses:** 100%, up to $50. **Lenticular Lenses:** 100%, up to $60. If only one lens is needed, the allowance will be one-half the pair allowance.
Contact Lenses	• One pair of Contact Lenses (in lieu of glasses) payable every calendar year. • One pair of contact lenses will be covered when medically (visually) necessary (such as when the visual acuity of the Covered Individual is not correctable to 20/70 by the use of conventional type lenses, but can be improved to 20/70 or better by the use of contact lenses).	**Elective Contact Lenses**: Covered up to $100 allowance for contacts and contact lens exam (fitting and evaluation); 15% off contact lens exam (fitting and evaluation). **Medically Necessary Contact Lenses:** No charge.	**Contact Lenses**: The Plan pays 100% to a maximum of $60.
Low Vision services for severe visual problems not corrected with regular lenses	• Maximum allowance for all low vision benefits is $1,000/person every two years.	**Supplemental Testing:** Covered in full. **Supplemental Aids:** The Plan pays 75% of the cost.	**Supplemental Testing:** The Plan pays 100% to a maximum of $125. **Supplemental Aids:** The Plan pays 75% of the cost.

SCHEDULE OF VISION BENEFITS *See the Vision PPO Plan Exclusions and the Definitions Article of this document for important information.* If you reside outside the PPO service area (called Out-of-Area) claims are payable at the In-network level of benefits. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions Article and could result in balance billing to you.**			
Covered Vision Benefits	**Explanations and Limitations**	**Plan Pays**	
		In-Network Provider	**Non-Network Provider**
Diabetic Eyecare Plus Program (DEP Plus) • Limited vision-related examination is payable for individuals with Type1 & 2 diabetic retinopathy, diabetic macular edema and rubeosis (conditions that can produce vision symptoms such as blurry vision, transient loss of vision, trouble focusing and floating spots).	• Under this DEP Plus benefit, you submit your diabetic eye exam claims to your medical plan first for payment. Then later send the Explanation of Benefits (EOB) form to this vision plan for consideration of payment of any unpaid balance. • No coverage under this DEP Plus benefit for frames, lenses contact lenses or other materials, surgery, orthoptics, insulin or medication/supplies.	Eye exam: covered in full after a $20 copay. Special Ophthalmological services: Covered in full.	Not covered.

Vision PPO Plan Exclusions.

The following is a list of services and supplies or expenses **not covered (excluded) by the Vision Plan**. The Plan Administrator, and Vision Plan Claims Administrator to whom responsibility for the administration of the Vision Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

1. Lenses which are not required to correct a visual defect; plano lenses (less than a $\pm$.50 diopter power); or two pair of glasses in lieu of bifocals.
2. Sunglasses, plain or prescription, or safety glasses.
3. Services and materials:
   a. In connection with special procedures such as orthoptics and visual training,
   b. In connection with medical or surgical treatment,
   c. Provided under Workers' Compensation benefits.
4. Charges for which services or materials are provided under any group or other pre-payment plan arranged through an employer, union, trustee or association.
5. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, radial keratotomy (RK), automated keratoplasty (ALK) and laser assisted in situ keratomileusis (LASIK).
6. Vision services and supplies that cost more than the Plan's allowance or are performed/received more frequently than permitted by the Plan, as noted in the Schedule of Vision Benefits.
7. Orthoptics (vision training to improve the visual perception and coordination of the two eyes) and supplemental testing.
8. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
9. Glasses secured when there is no prescription charge, such as reading glasses obtained from a drugstore.
10. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK) or laser assisted in situ keratoplasty (LASIK), except that this Vision Plan does offer a discount on laser eye surgery when performed by In-network Vision providers.
11. Services or supplies received for an illness that is a result of war, whether declared or undeclared.
12. Vision check-ups or screenings requested by the participant's employer, school or government.
13. Experimental and/or investigational/unproven treatment or procedure.
14. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.

15. Services or supplies furnished before the effective date of vision benefit coverage or beyond the termination date of vision benefit coverage.
16. Expenses related to complications of a non-covered service.
17. Services performed outside of the United States of America.
18. The Vision Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Vision Plan will pay the cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras, such as:
    a. oversized lenses (larger than 61mm).
    b. cosmetic lenses and cosmetic processes.
    c. coated lenses (e.g. anti-reflective, color, mirror, scratch).
    d. photochromic tinted lenses (addition of substance to produce a color) except that Pink #1 and Pink #2 is covered.
    e. sunglasses/ultraviolet (UV) protected lenses (plain or prescription).
    f. laminated lenses.
    g. polycarbonate lenses.
    h. blended lenses.
    i. progressive multi-focal lenses.
    j. orthokeratology lenses for reshaping the cornea of the eye to improve vision.

Filing A Vision Claim/Appealing A Denied Claim.

When you use the services of an In-Network vision provider, you should pay the provider for your appropriate copay. The provider will typically send the remainder of their bill directly to the Vision Plan for reimbursement. Note however that you will need to pay the provider for any services you purchased that are in excess of the benefit allowed under the Vision Plan or are not covered by the Vision Plan.

If you use the services of a Non-Network vision provider, you will need to pay the provider for all services and then, at a later date but within 12 months of the date of service, submit the bill (and proof of payment) to the Vision Plan Claims Administrator (whose contact information is listed on the Quick Reference Chart in the front of this document). You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits.

Vision claims submitted beyond 12 months of the date of service may not be considered for reimbursement.

Reimbursement for services provided by or obtained from a Non-Network vision provider will be the **lesser** of the actual amount charged or the maximum amount listed in the Schedule of Vision Benefits under the column titled “Non-Network Provider” (minus your cost-sharing). Your appeal of any denied vision claims should be submitted to the Vision Plan Claims Administrator. See also the Claim Filing and Appeals Information Article for details on the post-service claims and appeals process.

ARTICLE 10: SHORT TERM DISABILITY INCOME BENEFITS

FOR ACTIVE EMPLOYEES

Overview.

An Injury or an Illness that prevents an eligible employee from working for even a short period of time can be an economic catastrophe for a family that relies on that employee's paycheck. Workers Compensation is available for work-related disabilities, and this disability benefit provides a wage replacement "time-loss" benefit for non-industrial (non-work-related) disabilities. The benefits available for Active employees are outlined in the Schedule of Short Term Disability Benefits below.

1. If disabled, an eligible employee can receive a weekly cash benefit in an amount up to the Plan maximums for as long as **twenty-six (26) weeks**. Payment of disability benefits may be coordinated with other sources of disability or retirement income such that the amounts payable from the source(s) and from this Plan will not exceed the amount specified in the Schedule of Short Term Disability Benefits.
2. **Waiting Period for Benefits:** Illness, sickness, and maternity benefits are payable after three (3) days. Accidental Injury benefits are payable from the onset of the disability.

An active employee's eligibility to qualify for disability benefits will automatically end on the earliest of the date your employment ends, you enter full-time military service or you retire.

Benefits/Schedule of Short Term Disability Benefits.

If an Active Employee has compensable time the week prior to or the week of their disability start date and the employee becomes Totally Disabled as a result of a non-occupational bodily Injury or Illness while covered hereunder, and as a result of the Injury or Illness is prevented from performing his regular or customary occupation, the Fund will, subject to the provisions hereinafter set forth, pay to the Active Employee the amount specified in the Schedule of Short Term Disability Benefits.

Totally Disabled means the inability of a covered employee to perform the material and substantial duties of his or her occupation as a result of an illness or injury, provided the condition was diagnosed by a Physician (defined below), and accepted by the Plan Administrator or its designee, as a permanent or continuing condition.

Physician means a person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Plan participant. Under this disability benefit, Physician also includes a Chiropractor, Physician Assistant, Certified Nurse Practitioner (CNP) in those states where a CNP is licensed to practice without the oversight of an MD or DO, Dentist, licensed psychologist, licensed clinical social worker, clinical specialist psychiatric nurse (CSPRN) or licensed and/or certified practitioner rendering counseling and therapy services when regulated by the appropriate state agency. A physical therapist is not a Physician.

If any period for which benefits are payable is less than a full week, payments will be made at the rate of 1/7 of the weekly benefit for each day in such period. Applicable Federal Insurance Contributions Act (FICA) taxes will be deducted from this amount and reported to the Internal Revenue Service on behalf of the Active Employee.

Short Term Disability Benefits will be reduced in full by disability income or retirement income you may receive, or be eligible to receive, from other sources including:

- a retirement plan or pension plan that UPS contributes to or sponsors (other than the Teamster – UPS National 401(k) Tax Deferred Savings Plan)
- a retirement plan or pension plan provided under any Collective Bargaining Agreement
- any retirement or disability benefits (primary and family) received from the Social Security Administration
- any benefits provided by a state-administered disability benefits program

It is a requirement of the Plan that you apply for the Social Security disability benefit as well as any state-provided disability benefits to which you may be entitled. If you do not apply, the Short -Term Disability claims administrator may estimate the Social Security amount that you could have received and offset your benefit by that amount.

Schedule of Short Term Disability Benefits	
Short-Term Disability The Short-Term Disability benefit protects a portion of the eligible employee's salary when they are disabled as a result of a non-work related injury or illness or are unable to work due to pregnancy.	a) The weekly benefit payable is **60% of average weekly base pay up to $500 per week**. b) The benefit is payable until the **employee ceases to be disabled or 26 weeks** of Short-Term Disability benefits. c) To receive the benefit the eligible employee must have a **Physician certify** that they are Totally Disabled and must be receiving regular care from a Physician in order to receive the Short-Term Disability benefit. d) **Waiting Period for Benefits:** Disability benefits begin on different dates depending on the reason for disability; however this date may not be earlier than the date when the Active Employee was first seen and personally treated for the disability by a Physician. 1) If the employee is injured in a non-work related accident: benefits are payable from the onset of the Disability as certified by a Physician. 2) If the employee is totally disabled due to non-work related illness: benefits are payable starting the 4th day of disability as certified by a Physician.

To file a claim for Short Term Disability Benefits, obtain the instructions and claim form from the Short Term Disability Claims Administrator or the Fund's website (contact information located on the Quick Reference Chart in the front of this document.

- The Plan Administrator or its designee reserves the right to review the medical records of the Physician(s) and other Health Care Provider(s) who provide medical care and treatment to you during any period in which Short Term Disability benefits are being requested or paid.
- The Plan Administrator or its designee reserves the right to have you examined, at the Plan's expense, by a Physician of its choice as often as may be reasonable during the period during which Short Term Disability benefits are being requested or paid.

Payment of Benefits.

The benefit payment amount is based on the average weekly pay as reported by the employee's employer.

Payments begin with the day of disability due to Illness that is specified in the Schedule of Short Term Disability Benefits. As to accidental Injuries, the benefits specified in the Schedule of Short Term Disability Benefits may be payable retroactively to the first day of disability.

Payments will continue for the period of disability up to a **maximum of 26 weeks for each disability**. In some jurisdictions, payment of disability benefits may be coordinated with state-provided benefits such that the amounts payable from the state and from this Plan will not exceed the amount specified in the applicable Schedule of Short Term Disability Benefits.

The foregoing short term disability benefit will only be provided for:

1. Those days on which an Active Employee is under the care of a legally qualified Physician.
2. A period of disability will be considered to have started on the date an Active Employee's disability has been determined to have occurred by competent medical opinion satisfactory to the Board of Trustees. However, this date may not be earlier than the date when an Active Employee was first seen and treated personally by a Physician for the disability.
3. Those days on which an Active Employee is not performing work for compensation or profit.
4. Disabilities which commence while covered as an Active Employee for Fund benefits.

5. Disabilities resulting from an Injury or Illness to which the workers' compensation laws or any similar laws are not applicable.

Period of Disability.

Successive periods of disability will be considered as one period of disability unless acceptable evidence is furnished that:

1. The causes of the latest disability absence cannot be connected with the causes of any of the prior disability absences and the latest disability absence occurs after an Active Employee returns to work on a full-time basis or part-time basis, as previously scheduled preceding the disability.
2. A connection with prior disability absences can be established but that, between the last of the previous disability absences which are connected and the latest one, an Active Employee has returned to work on a full-time basis or part-time basis (with similar hours as previously scheduled prior to their disability) for at least two consecutive weeks.

When Short Term Disability benefits Are Payable.

The Plan will pay Short Term Disability benefits while you are determined by the Plan Administrator or its designee to be Totally Disabled if:

1. You become Totally Disabled while you are covered for Short Term Disability Benefits;
2. You are and remain under the care of a Physician (as defined in this Article) while you are Totally Disabled; and
3. You are not engaged in any other occupation or employment for which you are or become qualified by education, experience, or training.

Exclusions And Limitations.

No Short Term Disability benefits will be paid if your disability results from an on-the-job illness or injury. STD benefits will not be paid out concurrently with Workers' Compensation benefits, even if you are also disabled because of an off-the-job injury or illness. However, if you are still disabled because of an off-the-job injury or illness when you are released to return to work from the occupational injury or illness, you will be eligible to apply for STD benefits at that time.

1. Intentionally self-inflicted injuries.
2. Participation in a felony.
3. War, or act of war (whether such is declared or not), insurrection, rebellion or participation in a riot or civil commotion.
4. Serving on active duty in an armed forces of any government.
5. Any vague or indefinable condition that cannot be described by a standard medical nomenclature diagnosis.

No STD benefits are payable for days when you receive Workers' Compensation benefits.

When Payment Of Short Term Disability Benefits Ends.

Payment of Short Term Disability benefits ends at the **earlier** of:

1. the date on which you cease to have a disability that qualifies you for benefits under this disability benefit;
2. after 26 weeks of Short Term Disability benefits have been paid.

If your employment terminates for any reason during a Period of Disability, Short Term Disability benefits will continue to be paid for the period indicated immediately above.

ARTICLE 11: DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Overview

This Article outlines the self-funded Death and Accidental Death and Dismemberment (AD&D) benefits.

Eligibility for Death Benefits.

Death Benefits for Active Employees: If an Active Employee dies from any cause while covered under this Plan or within 31 days of termination of eligibility, the Fund will pay a death benefit to the designated beneficiary, an amount equal to the amount set forth in the Schedule of Death Benefits.

Death Benefits for Dependents of Active Employees (available under all plans): If an Active Employee's Dependent dies from any cause, while covered under this Plan or within 31 days of termination of eligibility, the Fund will pay a death benefit to the employee in an amount equal to the amount set forth in the Schedule of Death Benefits.

SCHEDULE OF DEATH BENEFITS	
Employee Death Benefit and Dependent Death Benefit • The plan pays a benefit in the event of the eligible employee's death to their beneficiar(y)ies. • The plan pays the eligible employee a benefit in the event of the death of a dependent.	**Employee Death benefits:** • For Full-Time employees the death benefit is equal to 2080 multiplied by the eligible employee's hourly wage, to a maximum of $100,000 and a minimum of $40,000. • For Part-Time employees the death benefit is equal to 1040 multiplied by the eligible employee's hourly wage, to a maximum of $100,000 and a minimum of $40,000. **Dependent Death benefits:** • The benefit payable in the event of an eligible employee's lawful spouse's death is $5,000. • The benefit payable in the event of an eligible employee's dependent child's death is $2,500.

Accidental Death and Dismemberment Benefits for Active Employees.

If an Active Employee dies or loses one or both hands or feet, or the eyesight in one or both eyes as the result of accidental means within 90 days of the accident, the Fund will pay an amount equal to the amount set forth in the applicable Schedule of Accidental Death and Dismemberment Benefits. Payment shall be made only for the loss for which the largest amount is payable; however, no loss sustained prior to such accident shall be considered in determining the amount payable for such accident.

SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS	
Accidental Death and Dismemberment (AD&D) • The plan pays an additional benefit to the eligible employee's beneficiar(y)ies in the event their death was an accidental death. An accidental death is any death directly and solely resulting from external means or an external cause. • The plan pays the eligible employee a benefit if they become dismembered in an accident.	**Accidental Death benefit:** • For Full-Time employees the accidental death benefit is equal to 2080 multiplied by the eligible employee's hourly wage, to a maximum of $100,000 and a minimum of $40,000. • For Part-Time employees the accidental death benefit is equal to 1040 multiplied by the eligible employee's hourly wage to a maximum of $100,000 and a minimum of $40,000. **Accidental Dismemberment benefit:** Loss of hands or feet means severance at or above the wrist or ankle joints. A loss with regard to the eyes means total and irrecoverable loss of sight. The Plan has the right to require a medical examination in connection with a claim from accidental dismemberment. • The benefit payable in the event of loss of both hands or both feet or sight in both eyes is equal to 100% of what the individual would receive under the accidental death benefit above. • The benefit payable in the event of the loss of any combination of a hand, foot or sight in one eye is equal to 100% of what the individual would receive under the accidental death benefit above. • The benefit payable in the event of the loss of one hand, one foot or sight in one eye is equal to 50% of what the individual would receive under the accidental death benefit above.

2. No benefit is payable for death or dismemberment caused by any of the following:
    1. Disease, including mental illness, or medical or surgical treatment for disease;
    2. Infections except from an accidental cut or wound;
    3. Suicide or attempted suicide, whether sane or insane;
    4. War or international armed conflict;
    5. The intentional act of another person during a fight started by the Active Employee;
    6. Ingestion or injection of non-prescribed drugs or intentional overdose of any drug; or
    7. Participation in an illegal act that is in violation of a federal or state criminal statute.

Accelerated Death Benefit.

1. If a determination is made that an Active Employee has a life expectancy of 12 months or less as the result of a medical condition caused by injury or illness, a lump sum accelerated benefit equal to 50 percent of the death benefit amount may be payable to the Active Employee or party designated by the Active Employee. The balance of the Death benefit amount shall be payable to the designated beneficiary upon the death of the Active Employee.

Beneficiary Designation for Death and AD&D Benefits.

1. A beneficiary designation may be made, or changed, at any time by filing a properly completed form in writing with the Administrative Office. Such beneficiary designation or change will take effect when received by the Administrative Office. An Active Employee's final decree of divorce will operate as a revocation of a previous beneficiary designation by the Active Employee of that spouse.
2. If a beneficiary has not been designated or if the beneficiary predeceases the Active Employee, the Fund will make payment to one (1) or more of the following surviving relatives of the Active Employee in the following priority order: lawful spouse, child or children including legally adopted children in equal shares, parents in equal shares, brothers and/or sisters in equal shares, or to the Active Employee's estate.
3. Any benefits for loss of life payable to a minor may be paid to the legally appointed guardian of the minor.

Payment.

1. All employee Death Benefits will be paid to the Active Employee's Beneficiary. Death and Accidental Death and Dismemberment Benefits may not be assigned.

ARTICLE 12: CLAIM FILING AND APPEAL INFORMATION

Overview.

This Article describes the procedures for filing claims for certain benefits under this Plan and for appealing Adverse Benefit Determinations in connection with those claims in compliance with 29 CFR §2560.503-1.

- Claims covered by the procedures in this Article include those claims filed and appeals related to the self-funded Medical PPO Plan(s) (including the outpatient Prescription Drug benefits), Dental PPO Plan, Vision PPO Plan, the self-funded Short Term Disability benefits and self-funded Death and AD&D benefit.
- For claims administration and appeals under the insured Medical HMO plan and insured Short Term Disability benefits refer to the official documents and Certificates of Coverage of these insurance companies for details. Claim administration and appeal procedures for the insured plans are not described in this Article.

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this Article are designed to **afford you a full, fair and fast review of the claim to which it applies**.

This Article also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is experimental or investigational).

Qualified Medical Child Support Order (QMCSO).

A Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO or National Medical Support Notice, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO or National Medical Support Notice.

When You Must Repay Plan Benefits.

If it is found that the Plan benefits paid by the Plan are too much because:

1. some or all of the health care expenses were not payable by you or your covered Dependent; or
2. you or your covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or
3. you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid (See also the Subrogation section of the Coordination of Benefits Article);or
4. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or
5. the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;

then, the Plan will be entitled to

a. recover overpayments from the entity to which the overpayment was made or from the participant directly;

b. a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;

c. offset future benefits (that would otherwise be payable on behalf of you or your dependents) if necessary in order to recover such expenses; and/or

d. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

Time Limit For Initial Filing Of Health And Disability Claims.

All health claims must be submitted to the Plan within 12 months from the date of service.

All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information.
The Plan is not legally required to consider information submitted after the stated timeframe.

Coordination Of Benefits (COB) Provision.

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a person is covered so that the total benefits available will not exceed one hundred percent of allowable expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits Article for more information.

Additional Information Needed.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

When You Must Get Plan Approval In Advance Of Obtaining Health Care.

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this Article. You are not required to obtain approval in advance for emergency care including care provided in a hospital Emergency Room, or hospital admission for delivery of a baby.

Key Definitions.

Days: For the purpose of the claim filing and appeal procedures outlined in this Article, "days" refers to calendar days, not business days.

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination for is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
- a reduction in a benefit resulting from the application of any utilization management decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or
- a Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.
- A denial or exclusion of coverage for a point of service prescription drug benefit at a pharmacy is not an adverse benefit determination.

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this Article) in accordance with the Plan's claims procedures, described in this Article.

There are **six types of claims** covered by the procedures in this Article: **Pre-service, Urgent, Concurrent, Post-service, Disability, and Death and Accidental Death and Dismemberment** described later in this Article. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

A claim must include the following elements to trigger the Plan's claims processing procedures:

a. be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),
b. be **received by the Appropriate Claims Administrator** as that term is defined in this Article;
c. **name a specific individual including their social security number or Medicare HICN number**,
d. **name a specific medical condition or symptom**,
e. **name a specific treatment, service or product** for which approval or payment is requested,
f. **made in accordance with the Plan's claims filing procedures** described in this Article; and

g. **includes all information required by the Plan and it's Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits**.
h. **proof of death or accidental death and dismemberment**.

A claim is NOT:

a. a request made by **someone other than** the individual or his/her authorized representative;
b. a request made by a **person who will not identify himself/herself** (anonymous);
c. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
d. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
e. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal;
f. a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
g. a **submission of a prescription** with a subsequent Adverse Benefit Determination at the point of sale at a retail pharmacy or from a mail order service.
h. a **request for an eye exam, lenses, frames or contact lenses** with a subsequent Adverse Benefit Determination at the point of sale from the Plan's contracted in-network vision providers.
i. a request for death or AD&D benefits without providing **proof of death or accidental death and dismemberment.**

Appropriate Claims Administrator: means the companies/organizations and types of claims outlined in the chart below. (See the Quick Reference Chart in this document for the contact information for these Appropriate Claims Administrators).

The abbreviation "NA" in the chart below means "not applicable."

Appropriate Claims Administrator	Type of Claim Processed	Urgent Appeal	Concurrent Appeal	Pre-service Appeal	Post-Service Appeal
Medical PPO Plan Claims Administrator	Post-service claims	NA	NA	NA	Level One
Dental PPO Plan Claims Administrator	Pre-service and post-service claims	NA	NA	X	Level One
Vision PPO Plan Claims Administrator	Post-service claims	NA	NA	NA	Level One
Utilization Management Company for the Medical PPO Plan	Urgent, concurrent and pre-service claims	X	X	X	NA
Outpatient Prescription Drug Program	Outpatient drug urgent, concurrent, preservice and post-service claims	X	X	X	Level One
Administrative Office	Eligibility, Short Term Disability, Death and AD&D claims	NA	NA	NA	Level One appeal for Eligibility and Short Term Disability
Board of Trustees	Appeal determination for a variety of claims	NA	NA	NA	Level Two appeal for eligibility medical, dental, vision, and short term disability Appeals for Death and AD&D

Pre-Service Claim: A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require precertification (also called prior authorization) are listed in the Utilization Management Article 4 in this document.

The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing precertification (that were obtained without prior approval) if you were unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (precertification) procedure could have seriously jeopardized the patient's life or health.

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification, as determined by your Health Care Professional:

- could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function, or
- in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

The services that require precertification (also called prior authorization) are listed in the Utilization Management Article in this document.

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short. The services that will receive concurrent care review are listed in the Utilization Management Article in this document.

Post-Service Claim: A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

Death Claim and Accidental Death and Dismemberment (AD&D) Claim: A death claim and AD&D claim is a claim for benefits under the Plan to which the Plan conditions availability of the benefit on proof of a claimant's death or proof of accidental death or accidental dismemberment, described later in this Article.

Disability Claim: A disability claim is a claim for benefits under the short term disability benefits of the Plan, to which the Plan conditions the availability of the benefit on proof of a claimant's disability.

Health Care Professional: Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Tolled: Means stopped or suspended, particularly as it refers to time periods during the claims process.

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required contributions or self-payments. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.

Independent Review Organization or IRO: Means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan's external review provisions and current federal external review regulations.

Review Of Issues That Are Not A Claim As Defined In This Article.

A Plan participant may request review of an issue (that is not a claim as defined in this Article) by writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this document. The request will be reviewed and the participant will be advised of the decision within the timeframes applicable to post-service claims.

Authorized Representative.

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an Adverse Benefit Determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a network Health Care Professional if you designate in writing that the network Health Care Professional is to become your authorized representative (if that Health Care Professional is part of the claim appeal). Under this Plan non-network providers cannot automatically be designated to be an Authorized Representative, the plan participant must make a written designation if they desire a non-network provider to be their authorized representative for a claim appeal; however this designation does not extend to permit the non-network provider to file legal action on behalf of the participant or their claim appeal.

The Plan requires a written statement from an individual that he/she has designated an authorized representative along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form (available from the Administrative Office).

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to Administrative Office.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

How To File A Claim For Short Term Disability Income Benefits (Disability Claim Process).

1. A claim for disability benefits is a request for disability plan benefits made by you (an individual covered under the Short Term Disability Benefits) or your authorized representative (as defined in this Article) in accordance with the Plan's disability claims procedures, described below in this Article. See also the "Key Definitions" section of this Article for a definition of a "claim" and the information on what is and is not considered a claim.

   A claim regarding rescission of disability coverage will be treated as a disability claim.

   In the case of disability benefit claim determinations and claim appeals, the plan will take steps to ensure that claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits. Medical and vocational experts will be selected based on their professional qualifications.

   The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

2. Eligible employees who become totally disabled from a non-occupational illness should apply (file a claim) for disability benefits within 30 calendar days after the date on which the illness or injury began, according to the following steps. All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability.

3. Obtain a disability claim form from the Administrative Office. Complete the patient portion of the form. Then give the form to your physician to complete the health care provider section of the form. Return the completed disability claim form to the Administrative Office, whose contact information is listed on the Quick Reference Chart in this document. **Disability claims will be determined no later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.**

4. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information.

   (a) All disability claims including proof of disability must be provided to the Plan within 90 days from the date of onset of the disability. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.

   (b) The Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.

5. The Board of Trustees' designee determines if employees are eligible to receive disability benefits under this Plan. The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) no later than 45 calendar days from the date the Appropriate Claims Administrator receives the claim.

(a) This 45-day period may be **extended for up to 30 calendar days** provided the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.

(b) If, prior to the end of this first 30 day extension, the Appropriate Claims Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

(c) A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. **If the Appropriate Claims Administrator needs additional information from you to make its decision**, you will have at least 45 calendar days to submit the additional information. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)

6. Disability benefits begin when the claim for disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim.

7. **If the claim for disability benefits is approved**, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

8. **If the claim for disability benefits is denied** in whole or in part, a notice of this initial denial (Adverse Benefit Determination) will be provided to the employee in writing (or electronically, as applicable). This notice of initial denial will:
   (a) give the specific reason(s) for the denial of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the plan);
   (b) reference the specific Plan provision(s) on which the determination is based;
   (c) contain a statement that you are entitled to receive upon request, free access to and copies of document, records and other information relevant to your claim;
   (d) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   (e) provide an explanation of the Plan's appeal procedure along with time limits;
   (f) contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;
   (g) describe any applicable contractual limitation periods on benefit disputes (such as the Plan's time limit on when a lawsuit may be filed following an appeal);
   (h) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
   (i) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

9. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-474-3485.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-800-474-3485.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-800-474-3485.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-474-3485.

10. **If you disagree with a denial of a disability claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Disability Claim.

1. This Plan maintains a 2 level appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first level of appeal review and to the Board of Trustees for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with:
   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

(e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees' designee will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

2. A determination on the initial appeal will be made no later than **45 calendar days** from receipt of the appeal.

3. If still dissatisfied with the initial appeal level determination you will have **60 calendar days** under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this booklet.

4. The Board of Trustees or its designee will then make a determination on the second level appeal as follows:

(a) no later than the date of the Board of Trustees meeting that immediately follows the Plan's receipt of a request for review, when the request for appeal review is filed **within** 30 calendar days preceding the date of such meeting. If the appeal **is filed more than 30 days** before the next meeting, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review.

(b) If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made no later than the third meeting of the Board following the Plans' receipt of the request for review.

(c) If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) The Plan will notify you of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

5. **The Plan may obtain a 45-day extension if** you are notified of the need and reason for an extension before expiration of the initial 45-day period. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)

6. You will receive a notice of the appeal determination. If that determination is adverse, at each level of appeal, it will include:

(a) the specific reason(s) for the adverse appeal review decision of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the plan);

(b) reference the specific Plan provision(s) on which the determination is based;

(c) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(d) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) describe any applicable contractual limitation periods on benefit disputes (such as the Plan's time limit on when a lawsuit may be filed following an appeal);

(f) a statement of the voluntary Plan appeal procedures, if any;

(g) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

(h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(i) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-474-3485.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-800-474-3485.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-800-474-3485.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-474-3485.

8. This concludes the disability appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

How To File A Post-Service Claim For Benefits Under This Plan.

1. A claim for post-service benefits is a request for Plan benefits (that is not a pre-service claim) made by you or your authorized representative, in accordance with the Plan's claims procedures, described in this Article. See also the "Key Definitions" section of this Article for a definition of a "claim" and the information on what is and is not considered a claim.

2. Plan benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim. Generally, network Health Care Providers send their bill directly to the Plan.

3. Generally, Plan benefits for a network provider, Hospital or Health Care Facility will be paid directly to the provider or facility; however, the fact that the Plan may pay benefits directly to a provider does not give such provider "Beneficiary" status under ERISA. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. This is because the Plan's financial responsibility for eligible benefits is generally automatically assigned to the provider of the service unless the claim is marked that the bills have been paid by the covered person. For eligible claims, the Plan pays their portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider. When deductibles, coinsurance or copayments apply, you are responsible for paying your share of these charges.

4. Often, when health care services are provided through the Preferred Provider Organization (PPO), the PPO network Health Care Facility/Provider will usually submit the written proof of claim directly to the Network for repricing or to the Appropriate Claims Administrator. This means that when using network providers there are generally no forms or claims or paperwork to complete.

5. If you pay for non-network health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered dependent paid some or all of those charges. If non-network benefits are payable to you, they will be paid up to the amount allowed by the Plan for those expenses.

6. **For claims incurred outside the U.S. (foreign claims)**, in most cases you will have to pay the provider at the time of service. Then at a later date you can submit the foreign claim and your proof of payment to this Plan for consideration of reimbursement in accordance with Plan rules outlined in this document. If the provider located outside the U.S. does not require payment at the time of service, when such claims are determined to be payable by this Plan, payment for covered services will be sent to the plan participant. Foreign claims will be processed like any other non-network claim. The claims administrator will have the claim translated into English and then will determine the daily rate of exchange between the U.S. dollar and the applicable foreign currency. Then payment will be made to you so that you can forward payment to the appropriate provider outside the U.S. Payment is not made by this Plan to a provider outside the U.S.

7. **Claim Forms:** Occasionally a health care provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this Article) to find out if they require you to complete a claim form. If a claim form is required it may be obtained from the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.

(a) Complete the employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."

(b) The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:

1) A description of the services or supplies provided.
2) Details of the charges for those services or supplies, including CPT/CDT codes.
3) Diagnosis including ICD codes.
4) Date(s) the services or supplies were provided.
5) Patient's name, social security or ID number, address and date of birth.
6) Insured's name, social security or ID number, address and date of birth, if different from the patient.
7) Provider's name, address, phone number, professional degree or license, and federal tax identification number.

(c) Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.

(d) Complete a **separate claim form** for each person for whom Plan benefits are being requested.

(e) If another plan is the primary payer, send a copy of the other plan's **Explanation of Benefits (EOB)** along with the claim you submit to this Plan. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if a plan maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, how to appeal a claim, etc.

(f) Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.

(g) If at the time you submit your claim, you furnish evidence acceptable to the Plan that you or your covered dependent paid some or all of those charges, Plan benefits for covered services may be able to be paid to you up to the amount allowed by the Plan for those services.

8. In all instances, when deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.

9. The Appropriate Claims Administrator will review your post-service claim no later than **30 calendar days** from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.

(a) This 30-day period may be **extended one time for up to 15 additional calendar days** if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, specifies the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30 day period using a written Notice of Extension.

(b) The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.

(c) The Appropriate Claims Administrator will then make a claim determination no later than 1) 15 calendar days from the date the Plan receives the additional information, 2) the deadline of the initial 30 day post service claim period, or 3) the date of the 45 day time period in the Notice of Extension if no additional information is received.

(d) **Proof of Dependent Status:** (See also the Eligibility Article of this document for Proof of Dependent Status.)

1) When processing claims submitted on behalf of a **Newborn Dependent Child** the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (*e.g.* copy of certified birth certificate for newborn).
2) When processing claims submitted on behalf of a **Dependent Child who is age 26 or older,** the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g. disabled adult child verification).
3) If claims are submitted on behalf of a **Dependent for whom the Plan has not yet received proof of dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Plan Administrator of the child's eligibility for coverage, before the claim can be considered for payment.
4) When processing claims submitted on behalf of a **new Spouse**, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g. copy of marriage certificate).

(e) When processing **claims related to an accident** the Appropriate Claims Administrator may need information about the details of the accident in order to consider the claim for payment.

10. The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be

provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

11. **If the post-service claim is approved,** you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

12. **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) along with the Explanation of Benefits or EOB form. This notice of initial denial will:
    (a) identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
    (b) state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
    (c) give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
    (d) reference the specific Plan provision(s) on which the determination is based;
    (e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
    (f) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    (g) provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
    (h) contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
    (i) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
    (j) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
    (k) disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

13. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
    - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
    - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.

14. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

15. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Post-Service Claim.

1. This Plan maintains a 2 level appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first level of appeal review and to the Board of Trustees for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with:
    (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
    (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
    (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
    (d) free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse

Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

(e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

2. Under this Plan's 2 level appeal process, the Plan routes the first level of review to the Appropriate Claims Administrator who will make the first level determination on the post-service appeal no later than 30 calendar days from receipt of the appeal.

(a) There is **no extension permitted** in the first or second level of the appeal review process.

(b) You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.

(c) If still dissatisfied with the initial appeal level determination you will have 60 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this document.

3. The Board of Trustees then will make a second level determination according to the following timeframes:

(a) **If an appeal is filed with the Plan <u>more than 30 days</u> before the next Board meeting**, the review will occur at the next Board meeting date.

(b) **If an appeal is filed with the Plan <u>within 30 days</u> of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(c) If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

5. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

6. You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

(a) information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

(b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review;

(c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;

(d) reference the specific Plan provision(s) on which the determination is based;

(e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(f) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(g) an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

(h) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

(i) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
(j) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
(k) disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.

7. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

8. This concludes the post-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

How To File An Urgent Care Claim For Benefits Under This Plan.

1. If your claim involves urgent care (as defined earlier in this Article and as determined by your attending Health Care Professional), you may file the claim or the Plan will honor a Health Care Professional as your authorized representative in accordance with the Plan's urgent care claims procedures described below.

2. Urgent care claims (as defined previously in this Article) may be requested by you orally or by writing to the Appropriate Claims Administrator (e.g., Utilization Management Company, outpatient Prescription Benefit Program, Dental PPO Plan) whose contact information is listed on the Quick Reference Chart in this document.

3. In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.

4. The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

5. You will be notified of the Plan's benefit determination as soon as possible but **no later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.

6. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the Appropriate Claims Administrator, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

7. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

8. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
(a) identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
(b) state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;

(c) give the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
(d) reference the specific Plan provision(s) on which the determination is based;
(e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
(f) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
(g) provide an explanation of the Plan's internal appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the **expedited** appeal review process and external review process for urgent care claims;
(h) contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
(i) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
(j) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
(k) disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

9. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.

10. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

11. **If you disagree with a denial of an urgent care claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of An Urgent Care Claim.

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document.

2. You will be provided with:
   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   (d) free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;
   (e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
   (f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

3. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than **72 hours** after receipt of the appeal.

4. The notice of appeal review of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   (a) information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   (b) a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or external review;
   (c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   (d) reference the specific Plan provision(s) on which the determination is based;
   (e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   (f) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   (g) an explanation of the Plan's external review process (when external review is relevant), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
   (h) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   (i) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
   (j) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
   (k) disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.

6. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

7. This concludes the urgent care claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

How To File A Concurrent Claim For Benefits Under This Plan.

1. If your claim involves concurrent care (as that term is defined earlier in this Article), you may file the claim by writing (orally for an expedited review) to the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.

2. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.

3. The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit

Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

4. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this Article.

5. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this Article.

6. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than **3 calendar days** after the oral notice.

7. **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
   (a) identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   (b) state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   (c) give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
   (d) reference the specific Plan provision(s) on which the determination is based;
   (e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   (f) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   (g) provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
   (h) contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
   (i) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   (j) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   (k) disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

8. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.

9. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

10. **If you disagree with a denial of a concurrent claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Concurrent Care Claim.

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document.

2. You will be provided with:
   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   (d) free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;
   (e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
   (f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:
      1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
      2) provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

3. A determination will be made on the appeal (without the opportunity for extension) **as soon as possible before the benefit is reduced or treatment is terminated**.

4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   (a) information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   (b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal or external review;
   (c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   (d) reference the specific Plan provision(s) on which the determination is based;
   (e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   (f) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   (g) an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
   (h) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   (i) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
   (j) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
   (k) disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
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   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.
6. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
7. This concludes the concurrent claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

How To File A Pre-Service Claim For Benefits Under This Plan.

1. A claim for pre-service (as defined in this Article) must be made by a claimant or the claimant's authorized representative (as described in this Article) in accordance with this Plan's claims procedures outlined in this Article.
2. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Utilization Management Article of this document) to the Appropriate Claims Administrator (as defined in this Article).
3. The pre-service claim will be reviewed no later than **15 calendar days** from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
4. The 15 calendar day review period may be **extended one time for up to 15 additional calendar days** if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period by using a written Notice of Extension.
5. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
6. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
7. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
8. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will be made if no additional information is received.
9. The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
10. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).
11. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
    (a) identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
    (b) state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
    (c) give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
    (d) reference the specific Plan provision(s) on which the determination is based;

(e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
(f) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
(g) provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
(h) contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
(i) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
(j) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
(k) disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

12. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
    - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
    - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.
13. Participants and beneficiaries may request documents and plan instruments regarding whether the Plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
14. **If you disagree with a denial of a pre-service claim,** you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Pre-Service Claim.

1. This Plan maintains a 1-level appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator (contact information listed on the Quick Reference Chart in this document). You will be provided with:
    (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
    (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
    (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
    (d) free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;
    (e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
    (f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:
        1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
        2) provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

2. Under this Plan's 1-level appeal process, the Appropriate Claim Administrator will make the appeal determination on the pre-service appeal no later than **30 calendar days** from receipt of the appeal.

3. There is **no extension permitted** to the Plan in the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.

4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.

5. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

6. You will receive a notice of the appeal determination. If that determination is adverse, it will include the following:
   (a) information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   (b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   (c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   (d) reference the specific Plan provision(s) on which the determination is based;
   (e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
   (f) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   (g) an explanation of the Plan's external review process, along with any time limits and information regarding how to initiate, as well as a statement of the voluntary Plan appeal procedures, if any;
   (h) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   (i) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
   (j) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency" and
   (k) disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.

8. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

9. This concludes the pre-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

How To File A Claim For A Death Benefit Or An Accidental Death And Dismemberment Benefit.

A claim for a Death benefit or an Accidental Death and Dismemberment benefit is a request for plan benefits made by a beneficiary or your authorized representative (as defined in this Article) in accordance with the Plan's Death benefit and Accidental Death and Dismemberment Benefit procedures, described below in this Article. See also the "Key Definitions" subheading of this Article for a definition of a "claim" and the information on what is and is not considered a claim.

1. Written notice should be received by the Administrative Office within 3 years of the date of loss. The Administrative Office will subsequently mail a claim form for completion.

2. An initial determination by the Fund and notice of any decision will be given to the claimant within a reasonable period of time, but not later than **90 calendar days** after receipt of the claim.

3. You will be notified if you did not follow the claim process or if you need to submit additional information or records to prove a claim and provided 45 calendar days in which to obtain this additional information. The Plan reserves the right to have a Physician or Health Care Practitioner examine you (at the Plan's expense) as often as is reasonable while a claim for benefit is pending or payable.

4. The Board of Trustees or its designee determines if employees are eligible to receive benefits under this Plan. The Plan will review your claim and notify you or your authorized representative in writing (or electronically, as applicable) within a reasonable time, but no later than 90 calendar days from the date the Appropriate Claims Administrator receives the claim.

   a) This 90-day period may be **extended one time for up to 90 calendar days** provided the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 90-day period, that additional time is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.

   b) A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. If the Appropriate Claims Administrator needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

5. The Death benefit check will be forwarded to the beneficiary designated by you. Dismemberment benefits will be paid to you, the employee. For more detailed instructions, call the Administrative Office.

6. If the claim for benefits is denied in whole or in part, a notice of this initial denial (adverse benefit determination) will be provided to the employee in writing (or electronically, as applicable). This notice of initial denial will:
   (a) identify the claim involved (e.g. date of death);
   (b) state that, upon request and free of charge, a diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   (c) give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
   (d) reference the specific Plan provision(s) on which the determination is based;
   (e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   (f) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   (g) provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
   (h) contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
   (i) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   (j) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   (k) disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

   If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.

7. If you disagree with a denial of a disability claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial of a Death Benefit or Accidental Death And Dismemberment (AD&D) Benefit.

This Plan maintains a one-level of appeal process. Appeals must be submitted in writing to the Board of Trustees (contact information listed on the Quick Reference chart in the front of this booklet).

1. Under the Plan's 1-level appeal process, you will be provided with:

a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

d) free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;

e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:
   1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
   2) provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

2. The Board of Trustees or its designee will then make a determination on the second level appeal as follows:
   a) no later than the date of the Board of Trustees meeting that immediately follows the Plan's receipt of a request for review, when the request for appeal review is filed **within** 30 calendar days preceding the date of such meeting. If the appeal **is filed more than 30 days** before the next meeting, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review.
   b) If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made no later than the third meeting of the Board following the Plans' receipt of the request for review.
   c) If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
   d) The Plan will notify you of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

3. The Plan may obtain a **45-day extension** if you are notified of the need and reason for an extension before expiration of the initial 45-day period. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)

4. You will receive a notice of the appeal determination. If that determination is adverse, it will include the following:
   a) the specific reason(s) for the adverse appeal review decision;
   b) reference the specific Plan provision(s) on which the determination is based;
   c) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   d) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   e) a statement of the voluntary Plan appeal procedures, if any;
   f) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   g) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   h) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

5. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

6. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-215-2039.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-215-2039.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-855-215-2039.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-215-2039.

8. This concludes the Death and Accidental Death and Dismemberment appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

Outline Of The Timeframes For The Claim Filing And Claim Appeal Process.

Overview of Claims and Appeals Timeframes						
	Urgent	**Concurrent**	**Pre-service**	**Post-service**	**Disability**	**Death and AD&D**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days	45 days	90 days
Extension permitted during initial benefit determination?	No[1]	No	Yes, one 15-day extension.	Yes, one 15-day extension.	Yes, up to 2 extensions each 30 days in duration.	Yes, one 90-day extension.
First (initial) Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	30 days	30 days for the first level and within the timeframe for Board meetings for level 2.	45 days for the first level and within the timeframe for Board meetings for level 2.	Within the timeframe for Board meetings.
Second Appeal Review must be submitted to the Plan within:	NA	NA	NA	60 days	60 days	NA
Extension permitted during appeal review?	No	No	No	Yes, at Board level	Yes, a 45-day extension	Yes, a 45-day extension

[1] no formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

Post-service and Disability Appeal Timeframes for Multiemployer Plan with Committee or Boards of Trustees that meet at least Quarterly		
Appeal filed **within 30 days** of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal.	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Appeal filed **more than 30 days** before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.
Board's decision on the appeal to be provided to claimant as soon as possible after the Board decision but no later than 5 days after the Board's decision date.		

External Review Of Claims.

1. This External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

2. You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim is denied and it fits within the following parameters:

   (a) The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or

   (b) The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

3. **External review is not available for** any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this **external review process does not pertain** to claims for life/death benefits, AD&D, disability, dental or vision plan benefits. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

4. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

5. There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

6. **External Review of Standard (Non-Urgent) Claims**.

   (a) Your request for external review of a standard (not urgent) claim must be made, in writing, **within four (4) months of the date that you receive notice** of an Initial Claim Appeal Benefit Determination (first level of appeal) or when applicable, an adverse Claim Appeal Benefit Determination (second level of appeal). For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

   (b) An external review request on a standard claim should be made to the following appropriate **Plan designee**:

      1) The Medical Plan Claims Administrator, with respect to a denied medical plan claim not involving retail or mail order prescription drug expenses or behavioral health expenses;

      2) The Prescription Drug Program provider, with respect to a denied claim involving outpatient retail or mail order prescription drug expenses;

      3) The Utilization Management Program provider, with respect to a denied Pre-service or concurrent review determination not involving prescription drug expenses or behavioral health expenses;

   Contact information for the Medical Plan Claims Administrator, the Prescription Drug Program provider, the Behavioral Health Program provider and the Utilization Management Program provider, is identified in the Quick Reference Chart, as amended from time to time.

   (c) **Preliminary Review of Standard Claims**.

      1) Within five (5) business days of the Plan's or appropriate Plan designee's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:

         i You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

         ii The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;

         iii You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

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

2) Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

   i If your request is complete and eligible for external review; or

   ii If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

   iii If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

(d) **Review of Standard Claims by an Independent Review Organization (IRO)**.

1) If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

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

   ii Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

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

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

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

   v The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee **within 45 days** after the IRO receives the request for the external review.

      a) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

      b) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

   vi The assigned IRO's decision notice will contain:

      a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

b) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

c) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

e) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

f) A statement that judicial review may be available to you; and

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

7. **External Review of Expedited Urgent Care Claims**.

(a) You may request an expedited external review if:

1) you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

(b) Your request for an expedited external review of a non-standard claim should be made to the following appropriate **Plan designee**:

1) The Utilization Management Program provider, with respect to a denied Urgent, Pre-service or Concurrent review determination not involving outpatient retail or mail order prescription drug expenses or behavioral health expenses;

2) The Prescription Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;

Contact information for the Utilization Management Program provider and Prescription Drug Program provider is identified in the Quick Reference Chart, as amended from time to time.

(c) **Preliminary Review for an Expedited Claim**.

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

(d) **Review of Expedited Claim by an Independent Review Organization (IRO)**.

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

1) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

2) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

8. **Overview of the Timeframes During the Federal External Review Process**.

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan or appropriate Plan designee performs preliminary review	Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request	Immediately
• Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review	Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review	Immediately
• When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan or appropriate Plan designee assigns case to IRO	**In a timely manner**	**Expeditiously**
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan or appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses it's denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

Limitation On When A Lawsuit May Be Started.

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before courts or administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. Under this Plan a non-network health care provider/facility is not a claimant that is permitted to start a lawsuit or other legal action to obtain Plan benefits. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly. In addition, you are not required to exhaust external review before seeking judicial remedy.

(For post-service claims, notice that the issue will be decided at the second quarterly Board meeting, or if the Plan received the appeal within 30 days of a Board meeting, the third meeting from receipt.)

No lawsuit may be started more than one year after the date of the final determination of the Trustees or their claim-review designee.

Discretionary Authority Of Plan Administrator And Designees.

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Elimination Of Conflict Of Interest.

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility Of Payment.

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, Appropriate Claims Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

ARTICLE 13: COORDINATION OF BENEFITS (COB)

How Duplicate Coverage Occurs.

This Article describes the circumstances when you or your covered Dependents may be entitled to health care benefits under this Plan and may also be entitled to recover all or part of your health care expenses from some other source. Coordination of Benefits does not apply to outpatient prescription drug benefits.

In this Article the term "you" references all covered Plan Participants. In many of those cases, either this Plan or the other source of coverage (the primary plan or program) pays benefits or provides services first, and the other coverage (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

- Another group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA Continuation Coverage); or
- Medicare; or
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle insurance including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
- Workers' compensation.
- Coverage resulting from a judgment at law or settlement.
- Any responsible third party, its insurer, or any other source on behalf of that party.
- Any first party insurance (e.g. medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage).
- Any policy from any insurance company or guarantor of a third party
- Any other source (e.g. crime victim restitution, medical, disability, school insurance).

The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party. Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

This Article describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the Plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in this Article). Duplicate recovery of health care expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

Coordination of Benefits or COB applies to members who are covered by more than one health care plan (meaning they have duplicate coverage). Coordinating benefits helps ensure that these members will receive the benefits they are entitled to while avoiding overpayment by either plan.

When a member is covered by more than one health plan (for example, when a spouse is covered under this group plan as well as under the spouse's own employer sponsored health plan), one plan is considered to be the primary payer and the other is considered to be the secondary payer. The primary payer covers the major portion of the bill according to that Plan's allowances, and the secondary payer covers some or all of the remaining allowable expenses.

Other types of duplicate coverage include but are not limited to Medicare, Medicaid, motor vehicle insurance, or third party liability insurance.

Members who are covered by more than one medical, dental or vision plan must let this Plan's Claims Administrators know about <u>all</u> the additional medical, dental and vision coverages they have. Contact information for the claims administrators is located on the Quick Reference Chart in the front of this document.

The COB provisions of each plan determine which plan is primary. Benefits are then coordinated among all of the health plans, and payments do not typically exceed 100% of charges for the covered services. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when a member actually recovers some or all of their losses from a third party (see also the Third Party Liability provisions in this Article). This Article describes the COB provisions of this Plan.

Coverage Under More Than One Group Health Plan. When And How Coordination Of Benefits (COB) Applies.

1. For the purposes of this Coordination of Benefits Article, the word "plan" refers to any group medical policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical services incurred by the Covered Individual or that provides health care services to the Covered Individual. A "group plan" provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Covered Individual with COBRA Continuation Coverage).

2. Many families have family members covered by more than one medical plan. If this is the case with your family, **you must let this Plan and its Claims Administrators know about all medical plan coverages when you submit a claim.**

3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the Plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order Of Benefit Determination Rules.

The Overriding Rules

This Plan does not coordinate benefits with an individual plan. This means that when a plan participant is covered by this Plan and also covered by an individual (non-group) plan/policy, including a policy through the Health Insurance Marketplace, this Plan will not pay benefits toward the unpaid amount related to claims resulting from an individual plan/policy.

A. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

B. When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than a dependent, for example, as an employee, retiree, member or subscriber is the primary plan that pays first; and the Plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (that is, the Plan covering the person as a retired employee); then the order of benefits is reversed, so that the Plan covering the person as a dependent pays first; and the Plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose Birthday falls later in the calendar year pays second, if:

1. the parents are married;

2. the parents are not separated (whether or not they ever have been married); or

3. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If both parents have the same Birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that has covered the other parent for the shorter period of time pays second.

C. The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent

with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current Spouse does, the Plan of the Spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.

If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the Plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the Plan that covers the parent whose Birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the Plans of the parents and their Spouses (if any) is:

1. The plan of the custodial parent pays first; and
2. The plan of the Spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third; and
4. The plan of the Spouse of the non-custodial parent pays last.

F. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parents coverage and the dependent's self or spouse coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the dependent.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the Plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

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

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.

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

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

1. in the amount or scope of a plan's benefits;
2. in the entity that pays, provides or administers the Plan; or
3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the Plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

How Much This Plan Pays When It Is Secondary.

Secondary Liability of this Plan: When this Plan pays second, it will pay, 100% of "Allowable Expenses" **less** whatever payments were actually made by the Plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans for each claim as it is processed is not more than 100% of total allowable expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the Plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is determined (by the Plan Administrator it is designee) to be Medically Necessary.
- If the coordinating plans determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest Allowed Charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines benefits on the basis of an Allowed charge amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration Of COB.

1. To administer COB, the Plan reserves the right to:
   - exchange information with other plans involved in paying claims;
   - require that you or your Health Care Provider furnish any necessary information;
   - reimburse any plan that made payments this Plan should have made; or
   - recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.
2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
4. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

5. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO, ACO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's Allowed charge.

6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.

7. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Coordination Of Benefits With Medicare.

A. Entitlement to Medicare Coverage: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period).

B. Medicare Participants May Retain or Cancel Coverage Under This Plan: If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible employee remains actively employed, that employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If an eligible individual under this Plan is covered by Medicare and an employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage if there has been a COBRA Qualifying Event. See Article 16 for further information about COBRA Continuation Coverage.

The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

C. Coverage Under Medicare and This Plan When Totally Disabled: If an eligible employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible employee will no longer be considered to remain actively employed. As a result, once the employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more employees.

D. Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

E. Summary Chart on Coordination of Benefits (COB) with Medicare: If you are covered by Medicare and also have other group health plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	**Situation**	**Pays First**	**Pays Second**
Are covered by both Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage such as a group health plan has paid
Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working Spouse of any age	The employer has less than 20 employees*	Medicare	Group health plan
	The employer has 20 or more employees	Group health plan	Medicare

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	**Situation**	**Pays First**	**Pays Second**
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Group health plan (*e.g.* a retiree plan coverage)
Are disabled and covered by a large group health plan from your work or from a family member who is working	The employer has less than 100 employees**	Medicare	Group health plan
	You are entitled to Medicare or the Employer has 100 or more employees	Group health plan	Medicare
Have End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Are covered under worker's compensation because of a job-related injury or illness	Entitled to Medicare	Workers' compensation for worker's compensation-related claims	Usually does not apply however Medicare may make a conditional payment.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	Federal Black Lung Benefits Program for black lung-related claims	Medicare
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for the accident-related claims	Medicare
Are a veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service.	Usually does not apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider.	TRICARE may pay second
Are age 65 or over OR, are disabled and covered by both Medicare and COBRA	Entitled to Medicare	Medicare	COBRA
Have End-Stage Renal Disease (ESRD) and COBRA	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA
* or if it is part of a multiemployer plan where one employer has 20 or more employees, if the Plan has requested an exception that is approved by Medicare. ** and isn't part of a multiemployer plan where any employer has 100 or more employees. See also : http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf or 1-800-Medicare for more information.			

How Much This Plan Pays When It Is Secondary To Medicare.

1. **When Covered by this Plan and also by Medicare Parts A and B:** When an eligible individual under this Plan is also covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the same benefits provided for active employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.

2. **When Covered by this Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits:** If an individual is covered by both this Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program. Also, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/preauthorization, Case Management or utilization of In-Network provider requirements, this

Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

3. **When Covered by this Plan and Eligible for but Not Covered by Medicare:** When the Covered individual is covered by this Plan and is also **eligible for, but is not enrolled in Medicare Parts A or B**, this Plan pays the same benefits provided for active employees less the amounts that would have been paid by Medicare had the individual been covered by Medicare Parts A and/or B. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.
4. **When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.
5. **When Covered by this Plan and also by a Medicare Part D Prescription Drug Plan:** If you have dual coverage under both this Plan and Medicare Part D, this Plan pays as primary. The Prescription Drug Plan does automatically coordinate with Medicare.

For more information on Medicare Part D refer to www.medicare.gov
or contact the Administrative Office.

Coordination With Government And Other Programs.

A. **Medicaid**: If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

B. **TRICARE**: If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

C. **Veterans Affairs/Military Medical Facility Services**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.

D. **Motor Vehicle Coverage Required by Law**: If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

E. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

F. **Other Coverage Provided by State or Federal Law**: If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Workers' Compensation.

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. Before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Plan Administrator, (the Board of Trustees) or the Claims Administrator(s) of their rights to recover any payments that the Plan has advanced.

Acts of Third Parties, and Subrogation.

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise. (See the exclusion regarding Expenses for Which a Third Party Is Responsible

in the Medical PPO Plan Exclusions Article), but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), **subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee** and/or a representative, guardian, conservator, or trustee of the Covered Individual, **and/or Dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:**

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
3. without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
4. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule);
5. even if the recovery was reduced due to the negligence of the covered Employee or covered Dependent (sometimes referred to as "contributory negligence") or any other common law defense.

B. Reimbursement and/or Subrogation Agreement

The covered Employee **and/or** any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or Spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights**.

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

1. to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced; and
2. that the Plan has the first right of reimbursement from any judgment or settlement, including priority over any claim for non-medical charges, attorneys' fees or other costs and expenses; and
3. to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
4. to not assign the right of recovery to any third party without the specific consent of the Plan; and
5. to inform the Plan in writing if a covered Employee and/or covered Dependent(s) were injured by a third party and, within seven (7) days of such injury, provide the following information:
   (a) the name, address, and telephone number of the third party that in any way caused the injury, and of the attorney representing the third party;
   (b) the name, address and telephone number of the third party's insurer and any insurer of the covered Employee and/or covered Dependent(s);
   (c) the name, address and telephone number of your attorney with respect to the third party's act;
   (d) prior to the meeting, the date, time and location of any meeting between the third party or his attorney and the covered Employee and/or covered Dependent(s) or their attorney;
   (e) all terms of any settlement offer made by the third party or his insurer or the covered Employee's and/or covered Dependent's insurer;
   (f) all information discovered by the covered Employee and/or covered Dependent(s) or their attorney concerning the insurance coverage of the third party;
   (g) the amount and location of any money that is recovered by the covered Employee and/or covered Dependent(s) from the third party or his insurer or the covered Employee's and/or covered Dependent(s) insurer, and the date that the money was received;
   (h) prior to settlement, all information related to any oral or written settlement agreement between the covered Employee and/or covered Dependent and the third party or his insurer or the covered Employee's and/or covered Dependent's insurer;
   (i) all information regarding any legal action that has been brought on the covered Employee's and/or covered Dependent's behalf against the third party or his insurer; and

(j) all other information and assistance requested by the Plan, the Plan Administrator, or the Plan's authorized representative that the Plan determines are necessary to enforce its rights.

6. to notify and consult with the Plan Administrator or designee before initiating any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
7. to inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. Subrogation

1. By accepting an Advance, the covered Employee and/or covered Dependent(s) jointly agree that the Plan will be subrogated to the covered Employee and/or covered Dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.

2. Under its subrogation rights, the Plan may, at its discretion:

   a. initiate any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or

   b. intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

E. Application to Any Fund

1. The Plan's right to reimbursement and subrogation shall apply to any fund, account or other asset created:

   a. pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Employee and/or Dependent(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or

   b. as a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Dependent(s).

F. Lien and Segregation of Recovery

By accepting the Advance the covered Employee and/or covered Dependent agrees to the following:

1. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

2. The covered Employee, covered Dependent and those acting on their behalf, shall hold in trust for the benefit of the Plan that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.

3. Should the covered Employee, covered Dependent or those acting on their behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed. Such remedy shall be in addition to any other available remedies under the terms of the Health Plan and applicable law.

G. Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. Apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or
2. Garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s); or
3. Institute legal action to obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed. In such event, the covered Employee and/or covered Dependent(s) shall be liable for the amount Advanced as well as all of the Plan's costs of collection, including reasonable attorney fees and costs.

The Plan has six (6) years to seek reimbursement for all or part of an Advance received by a covered Employee and/or covered Dependent(s) because of any injury caused by a third party, and for which a covered Employee and/or Dependent or their counsel was awarded or received a monetary settlement from such injury from a court judgment, arbitration award, settlement or any other arrangement.

The six year timeframe begins from the date the Plan discovers that a covered Employee, covered Dependent(s) or their legal counsel was awarded or received such monetary recovery.

ARTICLE 14: GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

Information Required by ERISA.

The following information concerning the Welfare Plan is being provided to you in accordance with government regulations:

A. **The name and type of administration of the Plan**.

The Teamsters Western Region & Local 177 Health Care Plan of the Teamsters Western Region and New Jersey Health Care Fund is a welfare benefit plan providing medical expense (including behavioral health and outpatient prescription drugs), dental, vision, short-term disability and death and accidental death and dismemberment benefits to participants and beneficiaries. It is administered by a joint Board of Trustees consisting of four Union representatives and four Employer representatives.

The Medical PPO plan, Dental PPO plan, Vision PPO plan, Short Term Disability, and Death and Accidental Death and Dismemberment benefits, are self-funded with contributions from participating employers held in a Trust which is used to pay Plan benefits. Independent Claims Administrators pay benefits out of Trust assets (contact information is located on the Quick Reference Chart in the front of this document). In Hawaii, New Jersey and New York, STD benefits are effected by a state law-mandated plan. The Fund reimburses that plan for the STD benefits for which is it responsible in those states. In California, for STD benefits, the Fund coordinates with a state law-mandated plan up to the plan benefit levels.

The Kaiser HMO Medical Plan (including outpatient prescription drugs) is fully insured. Contact information for this HMO plan is listed on the Quick Reference Chart in this document but benefits are not described in this document.

B. **The name and address of the Plan Administrator/Plan Sponsor is**:

Board of Trustees for the Teamsters Western Region and New Jersey Health Care Fund
2550 W. Union Hills Drive, Suite 250
Phoenix, AZ 85027-5163
Phone: 855-215-2039

C. **Name and business addresses of the Trustees are**:

Labor	**Management**
Mr. Andrew Marshall, Chairman Teamsters Local 396 880 S Oak Park Rd Covina, CA 91724	Mr. Douglas Ruygrok, Secretary Teamsters Western Region & New Jersey Health Care Fund 2550 W. Union Hills Drive, Suite 290 Phoenix, AZ 85027
Mr. Alfred Betts Teamsters Local 177 282 Hillside Ave. Hillside, NJ 07205	Mr. Chris Langan Teamsters Western Region & New Jersey Health Care Fund 2550 W. Union Hills Drive, Suite 290 Phoenix, AZ 85027
Ms. Karla Schumann Teamsters Local 104 1450 South 27th Avenue Phoenix, AZ 85009	Mr. Brian Person Teamsters Western Region & New Jersey Health Care Fund 2550 W. Union Hills Drive, Suite 290 Phoenix, AZ 85027
Mr. Mark Davison Teamsters Local 162 1850 NE 162nd Ave Portland, OR 97230	Mr. Anthony DeCosmo Albertsons/Safeway, Inc. 6900 S Yosemite St. Centennial, CO 80012

D. **In addition to the Board of Trustees, the following person has been designated as agent for the service of legal process**:

J. Kenneth Kelley, Esq.
Ryan Rapp & Underwood, PLC
3200 North Central Avenue, Suite 2250
Phoenix, AZ 85012

Also, service of legal process may be made upon any Plan Trustee or the Plan Administrator.

E. **The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 86-6052021.**

F. **The Plan number assigned to this employee benefits welfare plan by the Board of Trustees is 501**.

G. **For purposes of maintaining the Fund's fiscal records, the plan year is December 1 through November 30**.

H. **Funding Medium**.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

I. **Financial Information**.

Contribution Sources: All Contributions to the Plan are made by Employers in accordance with collective bargaining agreements between Unions affiliated with the Teamsters Western Region and New Jersey Health Care Fund and participating employers. The collective bargaining agreements require contributions to the Plan at fixed rates. The Administrative Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreement. See the paragraph of this section entitled "Plan Documents" if you wish to obtain additional information about the collective bargaining agreement.

Organizations Accumulating Fund Assets: The Fund's assets and reserves are held in custody by Bank of New York Mellon and invested under the guidance of the Fund's investment consultant Biller & Associates. See the paragraph entitled "Plan Documents" if you wish to obtain additional information concerning the Fund's financing.

J. **Plan Information**.

Eligibility: The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are fully described in the Eligibility Article of this document.

Plan Regulations: All types of benefits provided by the Plan are set forth in the various Schedule of Benefits contained in this booklet.

K. **STATEMENT OF ERISA RIGHTS**.

Rights of Plan Participants

As a Participant in the Teamsters Western Region and New Jersey Health Care Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at the Plan Administrator's office (as noted on the Quick Reference Chart in the front of this document) and at other specified locations, such as worksites, all documents governing the Plan including insurance contracts, 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 (formerly known as the Pension and Welfare Benefit Administration).

Obtain, upon written request to the Plan Administrator, copies of the documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan descriptions. The Administrator may make reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In additional 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, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report form the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen the 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 fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit 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 (formerly known as the Pension and Welfare Benefit Administration).

L. **Claim Procedures: Claim Filing and Claim Appeals**.

The procedures to follow for filing a claim for benefits are set forth in Article 12. Certain claims for benefits must be submitted on claim forms made available by the Administrative Office or other claims administrator (for example, non-network medical PPO provider claims). Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. The procedures to follow for appealing an adverse claim determination are also set forth in Article 12.

Proof of Claim. All benefits will be paid by the Fund to the Eligible Employee as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character, and extent of the event for which the claim is made.

Claims Review Fiduciary (Claims Administrator): With respect to all matters regarding eligibility, contact the Administrative Office (contact information is on the Quick Reference Chart in the front of this document. With respect to adjudication of claims, refer to the following chart:

Benefit Programs	Funding	Claims Administrators (as listed on the Quick Reference Chart in the front of this document)
Medical PPO Plan	Self-funded	Various independent Claims Administrators
Outpatient Drug Benefits	Self-funded	Prescription Drug Program Administrator
Medical HMO Plan	Insured	
Dental PPO Plan	Self-funded	Dental Plan Claims Administrator
Vision PPO Plan	Self-funded	Vision Plan Claims Administrator
Short Term Disability	Self-funded	Administrative Office performs claims administration for all states except Hawaii, New Jersey and New York
Short Term Disability	Self-funded	Short Term Disability Insurance Company under an ASO agreement performs claim administration for residents of these states: Hawaii, New Jersey and New York
Death and AD&D Insurance	Self-funded	Administrative Office

Time Limit for Claims: Benefits will be paid by the Fund only if proof of claim is made within 90 days from the date on which expense with respect to which claim is made was incurred, unless it shall be shown by the Eligible Employee not to have been reasonably possible to provide proof within such time limit, but in no event shall benefits be allowed if proof of claim is made beyond 1 year from the date on which the expense was incurred.

Claim Evaluation: In determining the benefits payable under this Plan, the Board may use, on a consistent basis, such claims evaluation information as is generally available in the health care benefits field.

Facility of Payment: In the event the Fund determines that the Eligible Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Employee has not provided the Fund with an address at which he/she can be located for payment, the Fund may, during the lifetime of the Eligible Employee, pay any amount otherwise payable to the Eligible Employee, to the spouse, or to a relative by blood of the Eligible Employee, or to any other person or institution determined by the Fund to be equitably entitled.

In the event of the death of the Eligible Employee, before all amounts payable under the Plan, the Fund may pay any such amount to any person or institution determined by the Fund to be equitably entitled. The remainder of such amount shall be paid to one or more of the following surviving relatives of the Eligible Employee: lawful spouse, child or children, mother, father, brothers or sisters, or to the Eligible Employee's estate, as the Board of Trustees in its sole discretion may designate. Any payment made in accordance with this provision shall discharge the obligation of the Fund hereunder to the extent of such payment.

Claim to Benefits.

1. No Covered Individual or other person shall have any right or claim to benefits under this Plan or any right or any claim to payments from the Fund other than as specified in these Rules and Regulations, the Rules of the Fund and the provisions of the Trust Agreement. Any dispute as to eligibility, type, amount or duration of such benefits or any right or claim to payments from the Fund shall be resolved by the Board of Trustees, under and pursuant to the Fund and the Plan and its decision on the dispute, right or claim shall be final and binding upon all parties, subject only to such judicial review as may be in harmony with its federal labor policy.
2. Each individual whose claim for benefits under the Plan has been denied shall be provided adequate notice in writing setting forth the specific reasons for such denial and written in a manner calculated to be understood by the claimant. A claimant aggrieved by such decision may request review. The Trustees shall establish and publish to Covered Individuals Fund rules and procedures for review of denied claims. Such rules and procedures shall comply with federal law.
3. The Trustees have full and exclusive authority to determine all questions of coverage and eligibility, the method of providing or arranging for benefits and any other related matters. The Trustees are authorized to construe the Trust Agreement and the Rules and Regulations of the Plan. The Trustees may delegate all or a portion of their authority hereunder to a Claims Committee, or to such other appropriate named fiduciary as the Trustees may determine, in order to provide individuals with a full and fair review of claims.
4. Any legal action or suit to secure judicial review of a claim determination must be filed within one year of the date of the final determination of the Trustees or their claim-review delegate, or judicial review is time barred. The provisions of this Section shall be applied to an include any and every claim or right asserted under the Plan or against the Fund, regardless of whether or not the claimant was a "participant" or "beneficiary" or the Plan within the meaning of those terms as defined in ERISA.

M. **Newborns' and Mothers' Health Protection Act.**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing the length of stay not in excess of 48 hours (or 96 hours). Of course a longer stay will be allowed if the needs are such that a longer stay is medically necessary.

N. **Women's Health and Cancer Rights Act.**

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

This coverage is subject to the Plan's annual copayments, annual deductibles and coinsurance provisions.

O. **Plan Documents and Reports**.

You may examine the following documents at the Administrative Office during regular business hours, Monday through Friday, except holidays:

1. Trust Agreement;
2. Collective Bargaining Agreement;
3. Plan Documents, policies and all amendments;
4. Form 5500 or full Annual Report filed with the Internal Revenue Service and Department of Labor; and
5. List of Contributing Employers.

You may also obtain copies of the documents by writing for them and paying the reasonable cost of duplication. You should find out what the charges will be before requesting copies. If you prefer, you can arrange to examine these reports, during business hours, at your local Union office. To make such arrangements, call or write the Administrator at the Administrative Office. A summary of the annual report that gives details of the financial information about the Fund's operation is furnished free of charge to all Participants.

P. **Spanish Language Assistance**.

Pongase en contacto con la oficina de administracion si no entiende los beneficios del Plan al numero (855) 215-2039.

This booklet contains a summary in English of your Plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Administrative Office.

Q. **HIPAA: Use And Disclosure Of Protected Health Information.**

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Teamsters Western Region and Local 177 Health Care Plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by an employer who participates in this Fund in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the Administrative Office. A copy is reproduced in the Appendix of this document. Information about HIPAA in this section is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan's Board of Trustees (the "Trustees") for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

1. Disclosure of PHI to the Trustees.

    a. **Disclosures by Plan**. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administrative functions that qualify as Payment or Health Care Operations. The Plan may, pursuant to 42 C.F.R. § 423.884(b), provide to the Trustees and/or the Centers for Medicare and Medicaid Services and/or its contractors, including but not limited to the Retiree Drug Subsidy Center, in the manner and in the form directed by the Trustees, the information required for the Trustees to comply with their obligations, if any, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and its implementing regulations, including subpart R of Part 423 of Title 42 of the Code of Federal Regulations.

The Plan, and the Plan Sponsor (Board of Trustees), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA.

When an Authorization Form is Needed: Generally the Plan will require that you sign a valid authorization form (available from the Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

This Plan will automatically recognize your legal Spouse as your Personal Representative and vice versa, without you having to complete a form to Appoint a Personal Representative. However, you may request that the Plan **not** automatically honor your legal Spouse as your Personal Representative by completing a form to Revoke a Personal Representative (available from the Privacy Officer). If you wish to revoke your Spouse as your Personal Representative, this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa. The recognition of your Spouse as your Personal Representative (and vice versa) is for the use and disclosure of payment-related PHI under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations.

b. **Disclosures by Business Associates**. The Plan's Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

c. **Disclosures by Other Covered Entities**. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

   i. The Plan's Payment activities,

   ii. Those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and

   iii. All of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

2. **Uses and Disclosures of PHI by the Trustees**. The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations.

3. **Privacy Safeguards**. The Trustees agree to:

   a. Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

   b. Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;

   c. Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

   d. Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

   e. Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;

   f. Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;

   g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

   h. Make available the information required to provide and accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

i. Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;

j. If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

k. Ensure that adequate separation between the Plan and the Trustees is established, as described below.

l. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

4. **Adequate Separation**. The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

   Only the following individuals may be given access to use and disclose PHI:

   a. The staff of the Administrative Office,

   b. Business Associates under contract to the Plan including but not limited to the medical claims administrator, preferred provider organization network, utilization management companies, outpatient prescription drug program, dental claims administrator, vision claims administrator.

   The persons described in this section above may only have access to and use and disclose PHI for Plan administration functions. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance.

5. In compliance with HIPAA Security regulations, the Plan Sponsor will:

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

   b. Ensure that the adequate separation discussed above, and required by 45 CFR § 504(f)(2)(iii) specific to electronic PHI, is supported by reasonable and appropriate security measures,

   c. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

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

R. **Authority, Plan Amendments, Termination Of Plan.**

The Board of Trustees reserve its right, in accordance with the Trust Agreement, Collective Bargaining Agreements and applicable law, to amend, modify or terminate/discontinue this Plan, or any part of it, whenever, in their judgment, conditions so warrant, without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

Allocation And Disposition Of Assets Upon Termination: In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- Terminate or amend either the amount of benefits or the eligibility requirements with respect to any benefits, even though such termination or amendment affects claims which have already accrued;
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these Plan Rules.

In addition, the Trust may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Board of Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Board of Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

Termination of Trust Provisions. The Trust Fund shall remain in full force and effect until terminated by the action of the Collective Bargaining parties and the Board of Trustees. In the event of terminations, the Trustees shall:

1. Make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and expenses incident to such termination.
2. Distribute the balance, if any, of the assets of the Trust Fund remaining in the hands of the Trustees in such manner as they determine will carry out the purpose of the Trust, including, but not limited to, the purchase of existing insurance benefits on a pro rata basis or the transfer of such funds to a successor trust having the same or similar purposes for the benefit of Participants.
3. Arrange for a final audit and report of their transactions and accounts for the purpose of terminating their Trusteeship.
4. In any event, upon termination, the Trustees may transfer may transfer group insurance policies and the balance, if any, of the assets of the Trust Fund remaining in the hands of the Trustees, or any portion thereof, to the Trustees of another Fund established for the purpose of providing substantially the same of greater group coverage than that contemplated by the Plan.
5. In no event shall any of the Fund, except for benefits due, revert to or be recoverable by any Participant, Employer or Union.

S. **Discretionary Authority Of Plan Administrator And Designees.**

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate/designee, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Any interpretation or determination by the Plan Administrator or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected.

T. **No Liability For Practice Of Medicine.**

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

U. **Right Of Plan To Require A Physical Examination.**

The Fund, at its own expense, shall have the right and opportunity to examine the person of any Covered Individual when and as often as it may reasonably require during the time a claim is pending, and also the right and opportunity to make an autopsy, in case of death, if not forbidden by law. Proof of claim forms, as well as other forms and methods of administration and procedure, will be solely determined by the Fund.

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician or Health Care Practitioner, to be examined by a Physician or Health Care Practitioner selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. The cost of such an examination will be paid by the Plan.

V. **Headings, Font And Style Do Not Modify Plan Provisions.**

The headings of Articles and subarticles and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

W. **Assignment.**

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, any Eligible Employee may direct that benefits due him/her be paid to an institution in which he/she or his/her Dependent is hospitalized, or to any provider of medical, dental or vision care services or supplies in consideration for Hospital, medical, dental or vision care services rendered or to be rendered.

Notwithstanding the foregoing, the Fund will honor any **"qualified medical child support order"** as defined by ERISA Section 609, received with respect to the Fund, and will make any payment required by ERISA Section 609 to a State which has acquired rights under that Section.

X. **Workers' Compensation.**

The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation insurance laws or similar legislation.

Y. **Utilization Review/Utilization Management.**

The Fund may provide utilization review/utilization management and or case management services through a provider which will provide patient health care information services to help Covered Individuals decide on their best treatment plan. Additionally, the Fund may make payments for expenses not normally covered by the Plan that are recommended in circumstances where such payment is to the advantage of the Covered Individual and the Fund.

Z. **No Right to Assets.**

No person other than the Trustees of the Trust shall have any right, title or interest in any of the income, property or funds received or held by or for the active employee accounts of the Fund, and no person shall have any right to benefits provided by the Plan except as expressly provided herein. Amounts paid erroneously to any person, including any Covered Individual, whether through the misconduct of the recipient or the mistake or oversight of the Trustees or their representatives, shall be held in trust by the recipient, and the Trust and its Trustees shall have an equitable lien thereon in addition to any other remedy provided by the Plan, by law, or otherwise. In no event will any active employee or that individual's dependents have any claim to assets held by or for the benefit of retired employees in the retired employee accounts of the Fund.

AA. **Maximum Liability of the Fund.**

Most of the benefits provided in these Rules and Regulations are paid directly from the assets of the Fund held for the benefit of active employees and their dependents, and there is no liability on the Fund, the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the active employee accounts of the Fund collected and available for the purpose of providing those benefits paid directly by the Fund.

BB. **Conflicts.**

The provisions of these Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of these Rules and Regulations and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

ARTICLE 15: DEFINITIONS

Definition of Terms

The following are definitions (in alphabetical order) of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to a particular Article are found in that Article.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related. See also the term Injury to Teeth.

Active Employee/Covered Employee: means any employee who meets the eligibility provisions as set forth in the Eligibility Article.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

Administrative Office: means the individual or entity designated and engaged by the Board of Trustees to administer the Plan. See the Quick Reference Chart in the front of this document.

Adverse Benefit Determination: See the Claim Filing and Appeal Information Article for the definition.

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering a Covered Individual (see also the Coordination of Benefits Article of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

Allowed Charge: means the amount this Plan allows as payment for eligible medically necessary services or supplies.

The allowed charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. **With respect to a network provider** (PPO network Health Care or Dental Care provider/facility), the fee set forth in the agreement between the PPO network Health Care or Dental Care Provider/facility and the PPO network or the Plan; or
2. **When Aetna administers claims, with respect to a non-network provider** allowed charge amount means **150% of the Medicare Allowable Rate** for the geographic area where the service is furnished. This is the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers. Medicare Allowable Rates are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. The claims administrator updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates. Geographic area is generally defined by the first three digits of the U.S. Postal Service zip codes; or

   When Blue Cross Blue Shield of Arizona administers claims, with respect to a non-network provider allowed charge amount means the allowed amount according to the BlueCard Host (the allowed charge of the Blue Plan in the region that the member resides in); or
3. **For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer,** including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed charge amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; or
4. The Health Care or Dental Care Provider's/facility's **actual billed charge**.
5. In accordance with federal law, **with respect to emergency services performed in a Non-Network Emergency Room (ER),** the Plan's allowance for ER visit facility fees is to pay the greater of:
   a) the negotiated amount for In-Network providers (the median amount if more than one amount to In-Network providers) (see "1" noted above), or
   b) 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
   c) (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

   See also the definition of emergency services in this Article.

The Plan's allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR) or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies. Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket Limit. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

In accordance with federal law, with respect to emergency services performed in a Non-Network Emergency Room (ER), the Plan's allowance for ER visit facility fees is to pay the **greater** of:

d) the negotiated amount for In-Network providers (the median amount if more than 1 amount to In-Network providers), or
e) 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
f) (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

See also the definition of **emergency services** in this Article.

Ambulance: A vehicle, helicopter, airplane or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located. An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this Article, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Applied Behavior Analysis (ABA) Therapy: is the design, implementation, and evaluation of environmental modifications to attempt to produce socially significant improvement in human behavior. In essence, systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization. ABA Therapy is a technique that some use for individuals diagnosed with Autism Spectrum Disorder (that refers to disorders defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) manual as autistic disorder, asperger's syndrome or pervasive developmental disorder).

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are medically necessary.

Assistant Surgeon: An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This plan allows payment of an assistant surgeon under the following conditions:

a. the individuals functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA) or Certified Surgical Assistant (CSA, SA-C), but not an employee of a hospital or surgical facility, or an intern, resident or other trainee; and
b. the use of an assistant surgeon is determined by the Plan Administrator or its designee to be medically necessary; and
c. the assistant surgeon actively participated in the surgical procedure (was not stand-by).

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between what this Plan pays and what the provider actually charged (the billed charges). Generally, amounts for which balance billing is made are never covered by this

Plan, even if the Plan's Out-of-Pocket limits are reached, because they usually involve expenses that are not covered by the Plan. See the provisions related to the Plan's Out-of-Pocket Limit for more details. See also the definition of Allowed Charge in this Article. Amounts over Allowed Charges do not count toward the Plan's Out-of-Pocket Limit and may result in balance billing. Typically, in-network providers do not balance bill. **Out-of-Network Health Care Providers commonly engage in balance billing a Covered Individual for any balance that may be due in addition to the amount payable by the Plan.**

Behavioral Health Disorder: Behavioral Health is an umbrella term that refers to mental health and/or substance abuse. A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical PPO Plan Exclusions Article of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioners: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a Master's degree or a nurse practitioner in independent practice who is qualified to perform behavioral health counseling or other qualified health care provider, and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment: Behavioral Health Treatment includes all inpatient services, including room and board, given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code (that is not excluded by this Plan) is considered a Behavioral Health Treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Behavioral Health Treatment Facility that qualifies as a Hospital is covered by this Plan as a Hospital and not a Behavioral Health Treatment Facility. A group home, halfway house or temporary shelter is not a Behavioral Health Treatment Facility under this Plan.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Birth (or Birthing) Center that is part of a Hospital, as defined in this Article, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Board of Trustees or Trustees: The individuals appointed as Trustees of the Teamsters Western Region and New Jersey Health Care Fund under the Fund's Agreement and Declaration of Trust.

Breastfeeding/Lactation Educator: is a provider who is currently certified as a lactation consultant by the International Board of Lactation Consultant Examiners (IBLCE). If not IBLCE certified, the provider MUST be a licensed, registered, or certified health care professional with referenced experience and training in lactation management. Breastfeeding/lactation educators help mothers initiate or maintain lactation and provide assessment, planning, intervention, and evaluation for optimal breastfeeding, working in conjunction with the mother's physician or midwife and/or baby's pediatrician. Under this Plan, a doula is not a payable breastfeeding education provider unless the doula also meets the definition here.

Calendar Year: The 12-month period beginning January 1 and ending December 31. For the Medical, Dental and Vision Plans, all annual Deductibles, Out-of-Pocket Limits and Annual Maximum Plan benefits are determined during the calendar year.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open heart surgery.

Case Management: A process, administered by the Utilization Management Company, in which its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the Fund to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Claims Administrator: The independent companies retained by the Plan to administer the medical, outpatient prescription drug dental, and vision plan benefits including claim processing and payment responsibilities and other administration or accounting services as specified by the Plan. The contact information for the various Claims Administrators is listed on the Quick Reference Chart in the front of this document.

Coinsurance: That portion of Eligible Medical Expenses for which the covered person has financial responsibility. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses in excess of the Plan's Deductible. In some instances, the Covered Individual may be responsible for paying a higher percentage of those expenses, and in other instances, no Coinsurance applies. Coinsurance amounts for the medical plan are listed on the applicable Schedule of Medical Benefits.

Collective Bargaining Agreement: Collective Bargaining Agreement means a labor agreement between a Contributing Employer and a Union which requires contributions to the Fund on behalf of employees of the employer.

Coinsurance: That portion of Eligible Medical, Dental and/or Vision Expenses for which the covered person has financial responsibility. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses after the Plan's deductible has been met. In some instances, the Covered Individual may be responsible for paying a higher percentage of those expenses, and in other instances, no coinsurance applies. Coinsurance amounts (when applicable) are listed on the Schedule of Medical Benefits, Schedule of Dental Benefits and Schedule of Vision Benefits.

Contributing Employer: "Contributing Employer" means any employer who is required by a collective bargaining agreement with the Union, the Trust Agreement, or any other written agreement, to make contributions to the Medical Plan for Active Employees or who, in fact, makes one (1) or more contributions to the Medical Plan for Active Employees. The term "Contributing Employer" shall also include the Local Unions if contributions are made to the Plan by a Local Union on behalf of its employees; provided the inclusion of said Local Unions is not a violation of any existing law or regulation.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical Expense for certain services. The services with a copay are listed on the applicable Schedule of Medical Benefits.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-sharing: A term to mean the amount of money a plan participant is to pay toward a service or item, versus the amount of money the Plan is to pay. Plans typically have three different types of cost-sharing provisions: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these types of cost-sharing. It is common for a Plan to change the amount of its cost-sharing provisions at least annually (more often if necessary).

Covered Individual: Any employee and that person's Dependents (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan, including COBRA beneficiaries.

COVID-19 Test: Diagnostic tests that are approved or authorized by the FDA to detect the virus that causes COVID-19 and detect COVID-19 virus antibodies.

COVID-19 Test Related Visit/Services: Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the COVID-19 Test, including the administration of such test, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care include helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards)

by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this plan under certain circumstances such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care or in conjunction with covered home health services.

Deductible: The amount of Eligible Medical Expenses for which a Covered Individual is responsible for paying before the Plan begins to pay benefits. The amount of Deductibles is set forth in the applicable Schedule of Benefits.

Dental: As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Dependent Child: For the purposes of this Plan, a Dependent Child is any of the Employee's children listed below who are under the age of 26 (whether married or unmarried):

a. **Biological children (son or daughter).** Proof of relationship and age may be required.

b. **Stepson or stepdaughter** (proof of relationship and age may be required).

c. **Legally adopted child or child placed for adoption** with the employee (proof of adoption or placement for adoption and age may be required). **Placed for adoption means** the assumption and retention by the eligible employee of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.

d. **Child under a permanent legal guardianship** (proof of court ordered guardianship may be required; ends when the child reaches age 18 or when guardianship ends, if earlier).

e. Dependent Child also includes a Dependent Child of an Eligible Employee, designated as an "Alternate Recipient" under the terms of a **Qualified Medical Child Support Order (QMCSO)** within the meaning of 609(a) of ERISA, 29 U.S.C. § 1169.

Disabled Adult Child: The Eligible Employee's unmarried Dependent Children who are incapable of self-sustaining employment by reasons of mental or physical disability and who are receiving Social Security disability benefits (Supplemental Security Income (SSI)) from the Social Security Administration will continue to be covered for benefits under this Plan provided such incapacity and SSI benefits commenced while the child was an eligible Dependent prior to the end of the month in which the Dependent attains age 26 years of age, and provided the child is dependent upon the Eligible Employee for support and maintenance.

Notification and proof of such disability must be submitted to the Administrative Office within thirty-one (31) days of the date the Dependent Child's coverage would otherwise terminate. If the adult child submitted for coverage does not qualify as a tax dependent under applicable state law, benefits may be imputed as income to the employee for the purposes of state tax. See also the definition of Disabled Child. The Plan (at its own expense) may have the child examined as often as needed while the handicap continues, generally no more often than once each year.

The following individuals are not eligible dependents under the weekly eligibility Plan: foster child, grandchild (child of a Dependent child), son-in-law or daughter-in-law, Domestic Partner or child of a Domestic Partner. A child whose coverage has terminated coverage under this Plan due to reaching the age limit, and then becomes disabled, is not eligible to re-enroll as a disabled Dependent child under this Plan.

Coverage for a Dependent Spouse ends on the date the spouse is divorced. Coverage ends on the date a child is no longer under a legal guardianship. For all other children, coverage ends at the end of the month in which the child no longer meets the Plan's definition of dependent child.

Disabled or Disability (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, (as that term is defined in this Plan) provided the condition was diagnosed by a Physician or Health Care Practitioner, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Disabled Child: A disabled child means:

a. He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your Plan; and
b. He or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to the Administrative Office no later than 31 days after the date your child reaches the maximum age under your Plan.

Coverage will cease when the first of the following occurs:

a. Cessation of the handicap
b. Failure to give proof that the handicap continues
c. Failure to have any required exam
d. Termination of the dependent coverage as to your child for any reason other than reaching the maximum age under the Plan.

Durable Medical Equipment: means items which can withstand repeated use, are primarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home and is not disposable or non-durable. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician/Health Care Practitioner's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: An Eligible Dependent is an individual that meets the definition of Dependent specific to their Plan as set forth in the Eligibility Article. An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility Article, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Eligible Employee: means each Active Employee and each Self-pay Employee.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Plan Administrator or its designee: are medically necessary, as defined in this Definitions Article; and the charges for them are Allowed Charges, as defined in this Definitions Article; and coverage for the services or supplies is not excluded; and the Maximum Plan benefits for those services or supplies has not been reached; and are for the diagnosis or treatment of an injury or illness, except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document.

Emergency Care/Emergency: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Emergency care means medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical or dental attention could reasonably be expected to result in any of the following:

1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

However, for emergency services performed in a hospital Emergency Room, the following definition applies:

Emergency Period: Emergency Period means any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), beginning on or after March 18, 2020, namely, the period during which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and a public health emergency declared by the Secretary pursuant to section 247d of the Social Security Act.

Emergency Services: means with respect to an emergency medical condition (defined below), a medical screening examination **within the emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient. The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver a newborn child (including the placenta).

The term "**emergency medical condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman of her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: See the definition of Active Employee.

Employer: See the definition of Contributing Employer.

Experimental and/or Investigational and/or Unproven: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational and/or Unproven. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Medical Review program, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:**

A. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;

B. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

C. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

D. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will <u>not</u> be considered Experimental and/or Investigational if it is:

- approved by the FDA as an "investigational new drug for treatment use"; or
- classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or
- approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was <u>not</u> approved for general use, and the FDA has <u>not</u> determined that such drug should not be prescribed for a given type of cancer.

E. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

F. Under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** The routine costs that are covered by this Plan are discussed below:

1. "**Routine costs**" means services and supplies incurred by a Covered Individual during participation in a clinical trial if such expenses would be covered under this plan for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

2. An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the

Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

3. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.
4. The plan may require that a Covered Individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.
5. The plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See the Claim Filing and Appeal Information Article for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for Precertification under the Plan's Medical Review program:**

A. Medical or dental records of the covered person;

B. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;

C. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;

D. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";

E. The published opinions of: the American Medical Association (AMA); or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or clinical policy bulletins of major insurance companies in the US such as Aetna or CIGNA, or Milliman Care Guidelines; or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.

F. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.

G. The latest edition of "The Medicare National Coverage Determinations Manual."

Formulary: A list of outpatient prescription drug products, including strength and dosages, available for use by Covered Individual. A formulary is also called a Preferred Drug List.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Essential Health Benefits: The Affordable Care Act defines essential health benefits to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Fund: See Trust.

Genetic Counseling: Counseling services provided before or in the absence of Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected

chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services includes physician-prescribed therapy for a child who is not walking at the expected age. Expenses for Habilitation services are not covered.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include outpatient Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, as those terms are defined in this Definitions Article.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Nurse Practitioner, Nurse Midwife, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, (Ophthalmologist, Optometrist, or Optician for vision plan benefits), Breastfeeding/Lactation Educator, a licensed psychologist; a licensed clinical social worker or clinical specialist psychiatric registered nurse (CSPRN) who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient. To the extent required by the Affordable Care Act regulations, a Health Care Practitioner includes a health care provider acting within the scope of the provider's license or certification under applicable State laws, and is performing a covered service under this Plan.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility, as those terms are defined in this Definitions Article.

HMO Network: Any Health Maintenance Organization engaged by the Fund to provide medical benefits in lieu of medical PPO Plan benefits to Covered Individuals.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this Article.

Home Health Care Agency: An agency or organization that provides a program of home health care and is approved by Medicare; and is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances will produce symptoms of an Illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar."

Hospice Care: means palliative and supportive medical and health care and other services provided to Terminally Ill Patients to meet special physical and emotional needs as part of dying so that a hospice patient may remain at home, to the maximum extent possible, with home-like inpatient care utilized only if and while it is necessary. A hospice agency must be licensed by the state of its situs and meet the certification requirements of a hospice agency as required by Medicare.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must be approved by Medicare; and be licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Hospice that is part of a Hospital, as defined in this Article, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, licensed and operating according to law, that:

a. is accredited by The Joint Commission; and

b. is approved by Medicare as a Hospital; and

c. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.

A hospital may include facilities for Behavioral Health treatment that are licensed and operated according to law. Any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Subacute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

Independent Freestanding Emergency Department is a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician or Health Care Practitioner and as compared to the person's previous condition.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Oral services in the Schedule of Medical Benefits.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Medically Necessary:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:

   1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and

   2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and

   3. is determined by the Plan Administrator or its designee to meet all of the following requirements:
      - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
      - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
      - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
      - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:

   1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

   2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that a Physician, Health Care Practitioner or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.

E. A Hospitalization or confinement to a Health Care Facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and appropriately be furnished in a Physician or Health Care Practitioner's or Dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

G. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is medically necessary.

H. A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

Medical Review: A managed care procedure to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation. Medical Review is sometimes referred to as Utilization Management, UM services, Utilization Review services, or UR services. Medical Review may be provided by professionals employed by a firm operating under a contract with the Plan for such purpose.

Medicare: means the benefits provided under Title XVIII of the U.S. Social Security Act of 1965 as it is amended from time to time.

Member Assistance Program (MAP): means any program whereby a Covered Individual may obtain counseling for mental, nervous, and emotional disorders and/or substance abuse problems. MAP may also be referred to as an Employee Assistance Program or EAP. If a MAP is available, it will be described in the applicable Schedule of Benefits.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a midwife or certified as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient. Generally a Midwife may **not** independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Morbidly Obese, Morbid Obesity: Under this Plan the term means the:

1. Presence of morbid obesity defined as either:
    a. body mass index (BMI) of 40 or greater; or
    b. BMI greater than 35 in conjunction with ANY of the following severe comorbidities:
        (1) coronary heart disease; or
        (2) type 2 diabetes mellitus; or
        (3) clinically significant obstructive sleep apnea (as determined by the Plan Administrator or its designee); or
        (4) high blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);
        (5) pulmonary hypertension;
        AND
2. Individual is at least 18 years of age and has completed growth (documentation of completion of bone growth);
    AND
3. Within the past 24 months the individual has participated in a Physician-supervised nutrition and exercise program (including dietitian consultation, increased physical activity, and behavioral modification), documented in the medical record. This Physician-supervised nutrition and exercise program must meet ALL of the following criteria:
    a. Participation in nutrition and exercise program must be supervised and monitored by a Physician working in cooperation with dietitians and/or nutritionists; AND
    b. Nutrition and exercise program must be 6 months or longer in duration; AND
    c. Participation in Physician-supervised nutrition and exercise program must be documented in the medical record by an attending Physician who does not perform bariatric surgery. Note: A Physician's summary letter is not sufficient documentation, actual medical records are required.

NOTE: BMI is calculated by dividing the individual's weight (in kilograms) by height (in meters) squared:

BMI = (weight in kilograms)
divided by (height in meters) times (height in meters)

or compute using the Obesity Education Initiative website: http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). .

Non-Network: See Out-of-Network.

Non-Participating Provider (Non-Preferred Provider): A Health Care or Dental Care Provider who **does not participate** in the Plan's Preferred Provider Organization (PPO).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and who is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. The following are not considered an office visit: a telephone discussion with a Physician or other Health Care Practitioner, internet/virtual office visit except as specifically covered in the schedule of medical benefits, a visit to a Health Care Practitioner's office where no office visit code is billed or a visit to a Health Care Practitioner's office for blood drawing, leaving a specimen, or receiving a routine injection.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or TMJ syndrome/dysfunction. See the definitions of Prognathism, Retrognathism, and TMJ syndrome/dysfunction.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Out-of-Network Services (Non-network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO) as distinguished from In-Network services, that are provided by a Health Care Provider that is a member of the PPO.

Out-of-Pocket Limit: The Out-of-Pocket Limit is the most you pay during a one year period (the calendar year) before your medical plan starts to pay 100% for covered essential health benefits. See the Medical PPO Plan Benefits Article for more details.

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are not incurred. However, a stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service.

Partial Hospitalization: means treatment of mental, nervous, or emotional disorders and substance abuse for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period.

Participant: "Participant" means an Eligible Employee.

Participating Provider: A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO).

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and who is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform physical therapy services including the evaluation and treatment of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physical Therapy: means rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

Physician: means a Physician or Surgeon (M.D. or D.O.) licensed to practice medicine in the state in which he/she practices and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient. To the extent that benefits are provided and while practicing within the scope of his license the term Physician includes a dentist, podiatrist, and chiropractor. See also the definition of Health Care Practitioner and Podiatrist.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility Article.

Plan: means the Plan or Plans of benefits established under the Trust Agreement for the Teamsters Western Region and New Jersey Health Care Fund which are described in this document.

Plan Administrator/Plan Sponsor: The Board of Trustees, who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: means the fiscal year, which begins December 1 and ends November 30. Benefits of the Medical Plan are provided on a calendar year basis beginning January 1 and ending December 31 of each year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

PPO: see Preferred Provider Organization.

Precertification: Precertification is a review procedure performed by a Medical Review firm under contract to the Plan **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service is appropriate and medically necessary. See the definition of Medical Review. See The Utilization Management Article 4 for information on precertification. Precertification is sometimes called precert, prior authorization, pre-approval, pre-admission review or pre-service review.

Preferred Provider. "Preferred Provider" means any Plan recognized provider, corporation, organization or entity which has contracted with the Plan to provide discounted fees for covered charges in accordance with this Plan.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (*e.g.* hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law. Pharmacy compounding is a practice in which a pharmacist combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug**: means a generic form of a brand-name drug. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA), and is basically a "copy" of a brand name drug. Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
5. **Specialty drug**: see the separate definition of Specialty drugs in this Article.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face. See also Orthognathic.

Progressive Lenses (Vision): Bifocal or trifocal lenses that appear to be single vision with no distinct lines between the various focal lengths.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Provider: See the definition of Health Care Provider.

Preventive Services/Preventive Care Benefits: are defined under the Patient Protection and Affordable Care Act (Health Care Reform) and include recommended services rated as "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), and preventive care and screenings for women and children as recommended by the Health Resources and Services Administration (HRSA).

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility Article of this document.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Facility: means a facility that is recognized by the Plan and licensed or certified to perform rehabilitative health care services by the state or jurisdiction where services are provided. Services of such a facility must also be among those covered by the Plan.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician or Health Care Practitioner when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. The applicable Schedule of Medical Benefits and the Medical PPO Plan Exclusions Article of this document determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy, Habilitation and Cardiac Rehabilitation. Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on therapy to help an individual attain certain functions that they never have acquired, such as speech therapy to assist a child with developmental speech delays and disorders.

A. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

B. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**

C. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be medically necessary for the purposes of this Plan.**

Residential Treatment Program/Facility/Care: is a non-acute hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a residential treatment facility (licensure requirements for this residential level of care may vary by state).

Respite Care: means care that is furnished to a Terminally Ill Patient when confined as an inpatient so that the family unit may have relief from the stress of the care of the Covered Individual.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face. See also Orthognathic.

Schedule of Benefits: means the chart describing benefits for a specific group appended to these Rules and Regulations.

Self-Pay Employee: means an Active Employee who subsequently loses eligibility who elects to continue coverage under the Plan in accordance with the Self-Pay provisions of this plan as described in the Eligibility Article.

Service Area: The geographic area serviced by the In-Network Health Care Providers who have agreements with any of the Plan's PPOs.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician or Health Care Practitioner; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

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

A. It is accredited by The Joint Commission as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and

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

C. It provides services under the supervision of Physicians or Health Care Practitioner; and

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

E. It maintains a daily medical record of each patient who is under the care of a licensed Physician or Health Care Practitioner.

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

Special Education: means specially designed instruction to meet unique needs of an individual, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Specialty Drugs: Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injectable, require an infusion, are taken orally or inhaled, may need to be administered by a health care practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before self-administration, and/or unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Specialty drugs are managed by the Prescription Drug Program under contract to the Plan. Examples of specialty drugs can include certain medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer.

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and who is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

Spouse: The Eligible Employee's **lawful Spouse**, which shall include only a person to whom the Eligible Employee is legally married. A Domestic Partner is not a Spouse and is not eligible under the Plan.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

A. It is accredited by The Joint Commission as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and

B. It maintains on its premises all facilities necessary for medical care and treatment; and

C. It provides services under the supervision of Physicians or Health Care Practitioner; and

D. It provides nursing services by or under the supervision of a licensed Registered Nurse.

Subacute care facility is sometimes referred to as a specialty hospital or post-acute care or long term acute care facility.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability section in the Coordination of Benefits Article for an explanation of how the Plan may use the right of subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical and/or dental benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Substance Abuse/Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan's benefit:

A. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of the Allowed Charge
Secondary and additional procedures	50% of the Allowed Charge per procedure

B. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of the Allowed Charge
First site secondary and additional procedures	50% of the Allowed Charge per procedure
Second site primary and additional procedures	50% of the Allowed Charge per procedure

Surgical Assistant: See Certified Surgical Assistant.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Terminally Ill Patient: means a patient whose Physician certifies that such patient is terminally ill and who is expected to live six (6) months or less.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient. For further information, see the definition of Occupational, Physical and Speech Therapy.

Total Disability, Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation as a result of an illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and sex, provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See also the definition of Disabled.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
- **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan.

See the Schedule of Medical Benefits Article and the Medical PPO Plan Exclusions Article for additional information regarding Transplants. See also the Utilization Management Article for information about precertification requirements for transplantation services.

Trust, Trust Fund or Fund: The Teamsters Western Region and New Jersey Health Care Fund.

Trust Agreement or Trust Document: means the Agreement and Declaration of Trust for the Teamsters Western Region and New Jersey Health Care Fund.

Trustees: see Board of Trustees.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Health Care Practitioners, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Management/Utilization Review: see Medical Review.

Utilization Management Company: An independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's Utilization Management services.

Vocational Rehabilitation: means teaching and training which allows an individual to resume his/her previous job or to train for a new job.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of Well Child Care is described under Wellness/Preventive Care in the Schedule of Medical Benefits.

ARTICLE 16: APPENDIX

This Appendix includes the following documents:

- HIPAA Notice of Privacy Practice
- COBRA Initial Notice

NOTICE OF PRIVACY PRACTICES

Teamsters Western Region and Local 177 Health Care Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice
December 6, 2018

The Teamsters Western Region and New Jersey Health Care Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1.
Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

The Plan will disclose your PHI to your spouse unless you object. The Plan may release PHI to a parent or guardian if allowed by law.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

(1) For treatment, payment and health care operations.

(2) Enrollment information can be provided to the Trustees.

(3) Summary health information can be provided to the Trustees for the purposes designated above.

(4) When required by law.

(5) When permitted for purposes of public health activities, including when necessary to report product defects, adverse reactions to medications and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(7) The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances, then the Plan can disclose the PHI to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the individual if disclosures is determined to be in the best interests of the individual by the Plan. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. Further, disclosure is permitted to handle organ, eye, or tissue donation and transplantation.

(11) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(13) Under circumstance, when the individual was, or is, Armed Forces personnel, for activities deemed necessary by appropriate military command authorities. PHI may also be disclosed to foreign military authorities, in certain circumstances, when the individual is, or was, a member of foreign military service. Also, to authorized federal officials for conducting national security and intelligence purposes, and for the protection of the President, other authorized persons, or heads of state.

(14) When permitted for fundraising activities, such as raising money for charities for financing its activities. If the Plan does not contact the individual about fundraising activities, the Plan will allow the individual to opt-out or stop receiving fundraising communications in the future.

(15) When permitted, the Plan may disclose PHI to a sponsor of a group health plan that is providing health care programs to the individual and when the group health plan has contracted with the Plan to administer a health care program for the individual on its behalf.

(16) When permitted, the Plan may use PHI for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does not use an individual's PHI for underwriting purposes, it is prohibited from using or disclosing genetic information for the underwriting process except with regard to issues of long-term care policies.

(17) When permitted to be given to researchers, after an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information and has approved the research.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have

been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2
Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

By default, the Plan will send Explanation of Benefits (EOBs) for all covered individuals to the employee unless otherwise requested. You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary, to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (including to business associates pursuant to a business associate agreement and to the Trustees as authorized by Plan or the HIPAA privacy regulations); (2) to individuals about their own PHI; (3) pursuant to your authorization; and (4) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice.

Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;

2. a court order of appointment of the person as the conservator or guardian of the individual; or

3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan will recognize certain individuals as Personal Representatives without you having to complete an Authorization for Release of Health Information Form. You may however request that the Plan not automatically honor the following individuals as your Personal Representative by notifying the Plan in writing at: PO Box 43110, Phoenix, Arizona 85080.

- For example, the Plan will automatically consider a spouse to be the personal representative of an employee and vice versa. The recognition of your spouse as your personal representative (and vice versa) is for the use and disclosure of PHI under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations.

- Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled “Rights of Individuals”.

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3
The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective December 6, 2018, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still

maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted on the Plan's website, www.ssatpa.com, you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;

2. uses or disclosures made to the individual;

3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;

4. uses or disclosures that are required by law; and

5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4
Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at: PO Box 43110, Phoenix, Arizona 85080. Phone 855-215-2039

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

INITIAL NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a **temporary** extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace at www.healthcare.gov. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA continuation coverage is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a Federal Law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Administrative Office at 1-(855) 215-2039.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced making you ineligible for group health coverage (including if you fail to work sufficient hours in a designated work period necessary to maintain plan eligibility), or
- Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced making the employee ineligible for group health coverage;
- Your spouse's employment ends for any reason (other than his or her gross misconduct);
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced making the employee ineligible for group health coverage;
- The parent-employee's employment ends for any reason (other than his or her gross misconduct);
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both) under Title XVIII;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Teamsters Western Region and Local 177 Health Care Plan has been notified that a qualifying event has occurred.

The following qualifying events **require notification from your employer**: end of employment; reduction of hours of employment making the employee ineligible for coverage; death of the employee; and commencement of a proceeding in bankruptcy with respect to the employer.

IMPORTANT: You Or A Qualified Beneficiary Must Give Notice Of Some Qualifying Events:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), **you must notify the Plan (by contacting the COBRA Administrator) within 60 days** after the Qualifying Event occurs (see notification steps below).

Notifying the Plan: Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must provide a written notice to the **Plan Administrator** (whose address is listed at the end of this document). The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce decree or legal separation agreement, death certificate document. If mailed, your notice must be postmarked no later than the last day of the required notice period.

NOTE: If such a written notice is not received by the Plan Administrator within the 60-day period you, the Qualified Beneficiary, will not be entitled to choose COBRA coverage.

The following documents are needed for their applicable event: death certificate; divorce decree; or Medicare card. You must provide this notice to the COBRA Administrator at:

Teamsters Western Region and Local 177 Health Care Plan
ATTN: COBRA Administrator
2550 W. Union Hills Drive, Suite 250 Phoenix, AZ 85027-5163.
Telephone: 855-215-2039

How Is COBRA Coverage Provided?

Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an **independent right to elect COBRA continuation** coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Duration of COBRA Coverage.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months for the spouse and dependents who are qualified beneficiaries.

There are three ways in which COBRA coverage can last longer than 18 months:

1. **Disability extension of 18-month period of continuation coverage:** If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled as of the date of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage, and you notify the COBRA Administrator in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, provided the disability lasts at least until the end of the 18-month period of COBRA coverage.

   Notifying the Plan: You or another family member must follow this procedure to notify the Plan by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. The written notice should be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA, the name of the disabled Qualified Beneficiary, the date the Qualified Beneficiary became disabled, and a copy of the written determination of disability from the Social Security Administration and that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period. **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. You must also notify the Plan when the disabled person is no longer determined to be disabled according to the Social Security Administration**.

2. **Second Qualifying Event extension of 18-month period of continuation coverage:** If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family who are Qualified Beneficiaries can get up to 18 additional months of COBRA continuation coverage (for a maximum of 36 months) if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to the spouse and any dependent children (if they are Qualified Beneficiaries) receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child.

   Medicare entitlement is not a Qualifying Event under this Plan because it does not result in loss of coverage for an employee. As a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are Qualified Beneficiaries.

   Notifying the Plan: You or another family member must follow this procedure to notify the Plan by sending a written notification to the COBRA Administrator of the second Qualifying Event within 60 days of that event. The written notice should be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA, the second Qualifying Event, the date of the second Qualifying Event and appropriate documentation in support of the second Qualifying Event such as divorce decree or legal separation agreement documents and that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period. **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage**.

3. **Medicare Extension for Spouse and Dependent Children:** When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. *For example*, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

Early Termination of COBRA Continuation Coverage.

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the amount due for COBRA coverage is **not paid in full and on time**;
2. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
3. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. (IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan).
4. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan);
6. The date the group health plan no longer provides group health coverage to any of its employees.

Other Rules and Requirements.

- **Same Rights as Active Employees to Add New Dependents**. A Qualified Beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the COBRA Administrator for more information.

- **Children Born to or Placed for Adoption with the Employee During COBRA Period**. A child born to, adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary provided that, if the covered employee is a Qualified Beneficiary, the employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the Plan's eligibility requirements (for example, age requirements).

- **Alternate Recipients Under Qualified Medical Child Support Orders (QMCSO).** A child of the covered employee, who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice received by the Plan Administrator during the employee's period of employment with the employer, is entitled the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

- **Be sure to promptly notify the COBRA Administrator (in writing) if you need to make a change to your COBRA coverage.** The COBRA Administrator must be notified in writing within 31 days of the date you wish to make such a change (adding or dropping dependents, for example).

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator (contact information is below). For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov. You may also contact the Plan Administrator at their address and phone number below.

Keep Your Plan Informed of Address Changes.

In order to protect your family's rights, **you should keep the Plan Administrator 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 or COBRA Administrator.

Plan Contact Information.

Remember, while you can call the Plan for information, any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. See the procedures to notify the Plan in writing that have been outlined in this document.

COBRA Administrator:

Teamsters Western Region and Local 177 Health Care Plan
ATTN: COBRA Administrator
2550 W. Union Hills Drive, Suite 250 Phoenix, AZ 85027-5163.
Telephone: 855-215-2039.

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Teamsters Western Region & Local 177

Health Care Plan

Southwest Service Administrators, Inc.

Phone: 855-215-2039

Fax: 602-324-0555

Mailing Address:

P.O. Box 43110

Phoenix, AZ 85080-3110

wr177healthcare.com