NATIONAL ROOFERS UNION AND EMPLOYERS JOINT HEALTH AND WELFARE FUND

Summary Plan Description and Benefit Rules

describing the
Medical, Dental, Vision, Disability Income,
Life and Accidental Death and Dismemberment Benefits

Amended, Restated and Effective: January 1, 2025

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INTRODUCTION

This booklet is designed to provide detailed information about the health and welfare benefits available to participants in the benefit plan of the National Roofers Union and Employers Joint Health and Welfare Fund.

The booklet serves as your Summary Plan Description (SPD) and Benefit Rules and replaces all other Summary Plan Descriptions and Benefit Rules and Regulations and amendments thereto previously provided to you. This booklet includes:

- A brief overview of the form of the Trust Fund and the responsibility of its Board of Trustees;
- A Quick Reference Chart which provides contact information about various companies that help administer the Plan;
- A summary of the Preferred Provider Organization (PPO) and Utilization Management (UM) Program available under the Medical Plan;
- Information on how to file a claim and how to appeal a denied claim;
- The Benefit Rules of the Plan, as amended by the Trustees to the date of printing, which includes Eligibility information, a Plan Eligibility Chart and Plan Benefits Chart, information on termination of benefits and COBRA self-payments;
- Information about Medical Plan benefits, Dental Plan benefits, Vision Plan benefits, as well as Life, AD&D and Disability Income benefits.
- Information on the Health Reimbursement Arrangement (HRA), tips on using the HRA account, and submitting claims to the HRA account for reimbursement;
- Information about the Plan and its operation, the disclosure of which is required by the governing federal law (Employee Retirement Income Security Act or ERISA).

The Trustees urge participants to review this booklet and **share it with family members** so that they will be familiar with the benefits available to them.

Obviously, not all questions can be answered in the booklet, so participants are also urged to call or write the Administrative Office, when necessary, to secure help in understanding and obtaining the benefits to which they are entitled.

No individual shall have accrued or vested rights to benefits under this Plan. “Vested rights” refers to benefits that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

The Board of Trustees makes every effort to administer the Plan carefully making changes to your Plan as the Trust’s financial condition changes and as mandated by law. Eligibility provisions and benefits may be increased or decreased (amended) from time to time. You will be notified if there are changes in plan benefits.

Questions You May Have

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Administrative Office at its phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the Administrative Office staff 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.

BRIEF OVERVIEW

The National Roofers Union and Employers Joint Health and Welfare Fund was formed subject to collective bargaining agreements by and between various local unions of the United Union of Roofers, Waterproofers, and Allied Workers and employers in the roofing industry. Due to economies of scale and a mobile workforce, the collective bargaining parties designed the Fund as a "multiemployer" Fund so that workers for the unionized employers in the industry could be covered by one health benefit program.

Under the multiemployer 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 union 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.

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 the Benefit Rules governing the provision of benefits. These Benefit Rules represent the efforts of the Trustees to secure the best benefits possible for the largest number of employees and dependents. The Benefit Rules for the Plan are reproduced in this booklet.

The Fund is not an insurance company that returns profits to its investors. The Fund uses all contributions and earning either to provide benefits to employees and their dependents or to pay necessary expenses.

Under the Collective Bargaining Agreements, the Agreement and Declaration of the Trust for the Fund, and the Benefit Rules of the Plan, the Board of Trustees has full and exclusive authority to determine all questions of coverage and eligibility, 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 Benefit Rules of the Plan. Any such determinations and any such constructions adopted by the Trustees in good faith are binding on the Employers, the Unions and the participants or beneficiaries of the Fund.

The Fund covers Eligible Persons from several states and differences in the benefits or eligibility occur due to negotiations and geographical needs. Be certain to refer to both the Plan Eligibility Chart and the Plan Benefits Chart in this document to determine the Plan that provides your benefits.

A Word About Privacy: In conformance with federal law, the Trust Fund has adopted policies and procedures concerning the confidentiality of protected health information (PHI). You will receive, separate and apart from this booklet, a "Notice of Privacy Practices" that summarizes how the Trust Fund uses and discloses PHI. More information about privacy is discussed in Article XI.

IMPORTANT NOTICE

You, your Spouse, or any of your Dependent Children must notify the Plan preferably within 30 days but no later than 60 days after the date that:

- a Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce);
- a Dependent Child reaches the Plan's limiting age; or
- a Dependent Child otherwise ceases to meet the Plan's definition of Dependent (see the Definitions Article of this document);
- a Dependent child has any physical or mental disability or ceases to have any physical or mental Disability;

Failure to give this Plan a timely notice will cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a Dependent Child who has a physical or mental disability to end when it otherwise might continue.

FOR HELP OR INFORMATION: When you need information, call the people listed in the following chart:

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Claims Administrator (Administrative Office) • Claim forms, Claim filing and Level 1 claim appeals for Dental Plan, Vision Plan, Life, AD&D, and Disability Income Benefits • Claim forms and Level 1 claim appeals for Medical Plan benefits • Eligibility and Plan Benefit Information • Pre-treatment Estimates for Dental Benefits • HRA Account Administrator • COBRA Administrator • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC)	**Wilson-McShane Corporation** 3001 Metro Drive – Suite 500 Bloomington, MN 55425 **Phone (952) 854-0795 or Toll-Free (800) 622-8780** Business hours are 8:00 am to 5:00 pm central time
PPO Network for the Medical Plan • Network Provider Directory • Additions/Deletions of Providers • Claim Filing for PPO Network Providers and Claim Filing for Non-PPO Providers	**CIGNA Open Access Plus (OAP) Network** www.cignasharedadministration.com or call CIGNA at 800-768-4695 Send claims to: CIGNA HealthCare P.O. Box 188004 Chattanooga, TN 37422 Electronic Payer ID: 62308 When accessing the online directory for the Open Access Plus (OAP) network: • Go to this website: www.cignasharedadministration.com • Click on the "Find a Doctor" button • Select the option for "Shared Administration OAP Provider Directory" • Enter your search location, i.e. Salt Lake City, UT • Select "medical" plans and then choose "OAP" from the drop down menu.
Utilization Management (UM) Company (UM Company) • Precertification Review • Case Management • Appeals of Level 1 UM review decisions	**CIGNA** For precertification of services other than CT, MRI and PET scan, **call CIGNA** at 800-768-4695. For precertification of CT, MRI and PET scans, **call** eviCore Healthcare at 866-249-3808.

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Employee Assistance Program (EAP)	**CIGNA EAP** 888.324.6612 or myCigna.com Employer ID: nationalroofers (for initial registration)
Prescription Drug Program • Retail Network Pharmacies • Mail Order (Home Delivery) Service • Reimbursement for Out-of-Network Retail Pharmacy use • Formulary • Precertification of certain outpatient drugs • Mobile app for pharmacy benefits • Narcotic Management Program • Specialty Drugs • ID Cards	**CIGNA Pharmacy** Customer Service Number: 800-244-6224 (*Customer service is available 24 hours a day, 7 days a week for precertification, ordering mail order drugs, questions, etc.*) **Mail Order and Reimbursement for Out-of-Network Retail Pharmacy Use:** Cigna Pharmacy Service Center P.O. Box 188053 Chattanooga, TN 37422 Website: www.mycigna.com
Disease Management • **For confidential information and assistance managing these health conditions**: asthma, chronic obstructive pulmonary disease (COPD), Type 1 and 2 diabetes, osteoarthritis, peripheral arterial disease, cardiac concerns like health disease, angina, coronary artery disease, congestive heart failure, acute myocardial infarction, low back pain, and behavioral concerns like depression, anxiety and bipolar disorder, please call this program's health professionals. • CIGNA's Health Advocates will identify and then contact members with these conditions. Health Advocates provide one on one coaching and online tools to help members best manage their condition.	**CIGNA (Health Advocates)** Call 800-768-4695
COBRA Administrator • COBRA information • Cost of COBRA and COBRA self-pay premium payments	**Wilson-McShane Corporation** 3001 Metro Drive – Suite 500 Bloomington, MN 55425 **Phone (952) 854-0795 or Toll-Free (800) 622-8780** Business hours are 8:00 am to 5:00 pm central time
HRA Account Administrator	**Wilson-McShane Corporation** 3001 Metro Drive – Suite 500 Bloomington, MN 55425 **Phone (952) 854-0795 or Toll-Free (800) 622-8780** Business hours are 8:00 am to 5:00 pm central time

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Plan Administrator • Level 2 Claim Appeals	**Board of Trustees, National Roofers Union Health & Welfare Fund** **Wilson-McShane Corporation** 3001 Metro Drive – Suite 500 Bloomington, MN 55425 **Phone (952) 854-0795 or Toll-Free (800) 622-8780**
HIPAA Privacy Officer **HIPAA Security Officer** • HIPAA Privacy Notice	**Wilson-McShane Corporation** 3001 Metro Drive – Suite 500 Bloomington, MN 55425 **Phone (952) 854-0795 or Toll-Free (800) 622-8780**

PREFERRED PROVIDER ORGANIZATION (PPO)

a. **Preferred Provider Organization (PPO)**:

1) The Plan's Preferred Provider Organizations (PPO) are networks of Hospitals, Physicians, laboratories and other Health Care Providers who are located within a Service Area (called "in-network") and who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to Plan Participants.

2) If you receive medically necessary services or supplies from a PPO Provider, you will pay a lower Coinsurance than if you received those medically necessary services or supplies from a Health Care Provider who is not a PPO Provider (called "out-of-network"). The PPO Provider has agreed to accept the Plan's payment plus any applicable Copayment or Coinsurance that you are responsible for paying as payment in full.

b. **In-Network and Out-Of-Network Services**: Plan Participants may obtain health care services from In-Network or Out-of-Network Health Care Providers.

In-Network Services:

1) In-Network Health Care Providers have agreements with the Plan's Preferred Provider Organizations (PPO) 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, except with respect to any applicable Deductible, the Plan Participant is responsible for paying the applicable Coinsurance on the discounted fees or Copayment for any medically necessary services or supplies, subject to the Plan's limitations and exclusions.

2) The in-network Health Care Provider generally deals with the Plan directly for any additional amount due.

3) **Because providers are added to and dropped from the PPO networks periodically throughout the year, it is best if you ask your Health Care Provider IF they are still participating with the PPO each time BEFORE you seek services.** You may also contact the PPO at their phone number and website listed on the Quick Reference Chart in the front of this document.

Out-Of-Network Services:

1) Out-of-Network (also called Out-of-Network or Non-PPO or Non-Contracted) Health Care Providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan Participant for the Allowed Charge (as defined in this document) for any medically necessary services or supplies, subject to the Plan's Deductibles, Coinsurance (on non-discounted services), Copayments limitations, and exclusions. Plan Participants must submit proof of claim before any such reimbursement will be made.

2) **Except in the case of No Surprises Act Services, Out-of-Network Health Care Providers may bill the Plan Participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing. <u>You can avoid balance billing by using In-Network providers</u>.**

   Balance Billing means 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. Amounts associated with balance billing are not covered by this Plan, except in the case of No Surprises Act Services. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge and Out-of-Pocket Limit. Note that, other than for services subject to the No Surprises Act, amounts over the Allowed Charge amount do not count toward the Plan's Out-of-Pocket limit and may result in Balance Billing to you. Typically, In-Network providers do not balance bill except in situations of third-party liability claims.

   <u>Out-of-Network Health Care Providers commonly engage in balance billing</u> a Plan participant for any balance that may be due in addition to the amount payable by the Plan, except for amounts related to No Surprises Act Services. <u>Generally, you can avoid Balance Billing by using In-Network providers</u>.

3) 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 PPO network, Administrative Office or Prescription Drug Provider at their phone number and website shown on the Quick Reference Chart in the front of this document.

4) See also the definition of Allowed Charge that addresses a Special Reimbursement provision for certain Out-of-Network provider situations.

c. **Directories Of Network Providers**

1) You can obtain a directory, at no cost, by calling the PPO Network telephone number or by viewing the directory from the PPO website as shown in the Quick Reference Chart in the front of this document, plus

2) Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year. At any time, you can find out if any Health Care Provider is a member of the Network by calling the telephone number or using the web address shown on the Quick Reference Chart in the front of this document.

3) If you obtain and rely upon incorrect information about whether a provider is a Network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.

d. **Continuity of Coverage.**

If you are a Continuing Care Patient, and the Plan terminates its contract with your in-network provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the plan, the Plan will do the following:

1. Notify you in a timely manner of the Plan's termination of its contracts with the in-network provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and

2. Allow you continued coverage at in-network cost sharing until the earlier of ninety (90) days or until you are no longer a Continuing Care Patient to allow for a transition of care to an in-network provider.

UTILIZATION MANAGEMENT (UM) PROGRAM

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 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 do not follow these procedures, your Plan requires an additional Deductible that you will be responsible for paying out of your own pocket.

Management of the Utilization Management Program

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

The health care professionals in the UM Company focus their review on the necessity and appropriateness of Hospital stays. 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.

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

a. The fact that your Physician recommends Surgery or Hospitalization does not mean that the recommended services or supplies will be considered medically necessary for determining coverage under the Medical Plan.

b. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a service is medically necessary does not 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.

c. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if:
   - the UM Company does not certify a proposed Surgery or other proposed medical treatment as medically necessary; or
   - the Plan will not pay regular Plan benefits for a Hospitalization or confinement in a Health Care Facility because the UM Company does not certify a proposed confinement; the benefits payable by the Plan may, however, be affected by the determination of the UM Company.

d. With respect to the administration of this Plan, the Fund, the Claims Administrator and the UM Company are <u>not</u> engaged in the practice of medicine, 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 services that have not been certified by the UM Company as medically necessary.

e. **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.

Precertification Review

a. **How Precertification Review Works**: Precertification Review is a procedure, administered primarily by the 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 is medically necessary. By having precertification review performed, you can avoid a financial penalty (explained later in this section).

b. **What Services Must Be Precertified (Approved) Before They Are Provided:**

The following services must be precertified to avoid a financial penalty, by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document).

- All Elective inpatient hospital admissions*, including transplants;

  *Note: precertification is required only for pregnant women with inpatient hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.
- Outpatient radiology imaging studies like CT, MRI, PET scans;
- Residential treatment program admission;
- Skilled nursing facility admission;
- Inpatient rehabilitation or habilitation facility admission;
- Inpatient hospice facility admission;
- Experimental or investigational services including routine costs associated with a clinical trial;
- Injectable drugs like Botox, Immune Globulin, Interferon & Antihemophilic factor;
- Spinal procedures, including all inpatient and outpatient spinal procedures if they are performed at a hospital or outpatient ambulatory surgical facility/center.
- Administration of a class of drugs called "survival motor neuron-2 (SMN2)-directed antisense oligonucleotides," which includes drugs such as Spinraza (nusinersen).
- Any technique that uses genes to treat or prevent disease (gene therapy) including but not limited to Kymriah, Yescarta, Luxtuma, etc.

- Certain outpatient drugs require precertification, by contacting the Prescription Drug Program (contact information on the Quick Reference Chart).

c. **How to Request Precertification (Pre-service Review):** 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. You or your Physician must call the UM Company (or for outpatient drugs call the Prescription Drug Program) at the telephone number shown in the Quick Reference Chart in the front of this document.

d. **Calls for Elective services should be made at least 10 days before the expected date of service.**

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, and phone number or address; the name of any hospital or 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 or providing the supplies.

If the preservice review process was not properly followed, you will be notified as soon as possible but not later than 5 calendar days after your request.

If additional information is needed, the UM Company/Prescription Drug Program will advise the caller. The UM Company/Prescription Drug Program will review the information provided, and will let you, your Physician and (where applicable) 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/Prescription Drug Program will usually respond to your treating Physician or other Health Care Provider **by telephone within 3 working days (but not 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.

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.

Concurrent (Continued Stay) Review

a. When you are receiving medical services in a hospital or other inpatient health care facility, the 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.

b. 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.

c. If at any point your stay is 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 your must leave the hospital, but if you choose to stay, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay was not medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. See also the section on "How to File Claims and Claim Appeals."

Emergency Hospitalization

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

Appealing a UM Determination (Appeals Process)

You may request an appeal of any adverse review decision made during precertification review, concurrent review, or the retrospective review process described in this section. To appeal see the Claims and Appeals portion of this document.

Failure To Follow Required Utilization Management Procedures (Very Important Information)

- If you do not follow the Precertification Review from the UM Company or Concurrent (Continued Stay) Review procedures, the Claims Administrator will reduce payable benefits by **an additional $250 per occurrence**. However, if you do not follow the Precertification Review from the UM Company for survival motor neuron-2 (SMN2)-directed antisense oligonucleotides or Gene Therapy, **no benefits are payable** for those treatments.
- If you do not follow the Precertification Review from the Prescription Drug Program or for any drug needing precertification, **no benefits are payable** for the drug that was not precertified.

The difference between the amount you would be responsible for paying based on the benefits that would be payable if the review procedure had been followed and the actual benefits payable because the review procedure was not followed will not count toward the Plan's Deductible or Annual Out-of-Pocket Limit.

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's needs are 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 section.

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 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.

HOW TO FILE CLAIMS AND CLAIM APPEALS

Overview

This section describes the procedures for filing claims for certain benefits under this Plan and for appealing adverse benefit determinations in connection with those claims. Claims covered by these procedures include those claims filed under the Medical Plan, Dental Plan, Vision Plan, HRA Plan, Weekly Disability Benefit, Life (Death) Insurance and AD&D benefits.

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 here are designed to **afford you a full, fair, and fast review of the claim to which it applies**.

This section 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 Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) 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 Trustees or their designee determines that it has received a QMCSO, 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.

For additional information (free of charge) regarding the procedures for administration of a National Medical Support Notice and QMCSOs, contact the Administrative Office.

When You Must Repay Plan Benefits

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

a. some or all of the health care expenses were not payable by you or your covered Dependent; or

b. 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

c. 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 Acts of Third Parties Article);or

d. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or

e. 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

1) recover overpayments from the entity to which the overpayment was made or from the participant directly;
2) 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;
3) 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
4) its attorney's fees, costs, and expenses incurred in recovering monies that were wrongfully paid.

TIME LIMIT FOR INITIAL FILING OF ANY CLAIMS

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

No Plan benefits will be paid for any claim not submitted within this period.

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 section. You are not required to obtain approval in advance for No Surprises Act Services, including emergency services and hospital admission for delivery of a baby.

Key Definitions

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

b. **Adverse Benefit Determination**: For the purpose of the initial and appeal claims processes, an adverse benefit determination 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 review 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.

c. **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 section) in accordance with the Plan's claims procedures, described in this document.

There are **six types of claims** covered by the procedures in this document: **Pre-service, Urgent, Concurrent, and Post-service, Life and Accidental Death and Dismemberment, and Disability**, described later in this section. 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:

1) be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),
2) be **received by the Appropriate Claims Administrator** as that term is defined in this section;
3) **name a specific individual**,
4) **name a specific medical condition or symptom**,
5) **name a specific treatment, service or product** for which approval or payment is requested, and
6) **made in accordance with the Plan's benefit claims filing procedures** described in this section.

A claim is NOT:

1) a request made by **someone other than** the individual or his/her authorized representative;
2) a request made by a **person who will not identify him/herself** (anonymous);
3) 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;
4) a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
5) 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;
6) 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.
7) 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.

d. **Appropriate Claims Administrator:** means the companies and types of claims outlined in the chart below. (See the Quick Reference Chart in the front of this document for the name and address of the Appropriate Claims Administrator).

Appropriate Claims Administrator	Types of Claims Processed
Administrative Office	• Medical, dental and vision post-service claims. • Disability claims • Life and AD&D claims • HRA Account post-service claims
Utilization Management Company	• Preservice, Urgent, and Concurrent claims
Prescription Drug Program	• Preservice and Urgent claims

e. **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. See the section on Utilization Management (UM) Program for information on precertification requirements of the Plan.

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.

f. **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 ability of the individual 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 described in the Utilization Management (UM) Program section of this document.

g. **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.

h. **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.

i. **Life Insurance/Accidental Death and Dismemberment Claim:** A life insurance/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 dismemberment, described later in this Article.

j. **Disability Claim:** A disability claim is a claim for weekly disability benefits under the Plan to which the Plan conditions the availability of the benefit on proof of a claimant's disability (including the Plans' determination of disability related to a weekly disability benefit, and/or eligibility extension due to a disability). A claim regarding rescission of disability coverage will be treated as a disability claim.

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

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

m. **Rescission:** Means a cancellation or discontinuance of coverage that has a retroactive effect, including coverage for disability benefits 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 (see also section 8 on Rescission of Coverage in the Eligibility Article).

n. **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 Section

A Plan Participant may request review of an issue (that is not a claim as defined in this section) by writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of 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 can also include an in-network Health Care Professional. The Plan will accept a statement by an in-network Health Care Professional that he/she is appealing on the patient's behalf, as an acceptable authorized representative.

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 Appropriate Claims Administrator or 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 the Appropriate Claims Administrator or the Administrative Office.

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), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

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

Complying With Mental Health Parity and Addiction Equity Act (MHPAEA)

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.

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

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

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:

a. 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 at their address listed on the Quick Reference Chart in the front of this document. **Disability claims will be determined not later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.**

b. 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.

c. Proof of disability must be provided to the Plan no later than 90 calendar days after the end of the period for which disability benefits are payable. 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.

d. 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.

e. The Board of Trustees 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) not later than 45 calendar days from the date the Appropriate Claims Administrator receives the claim.

f. 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.

g. 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.

h. 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.

i. 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.

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

k. **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:
   - 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);

- reference the specific Plan provision(s) on which the determination is based;
- contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim, records and other information;
- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- provide an explanation of the Plan's appeal procedure along with time limits;
- contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- 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);
- 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;
- 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;

If you do not understand English and have questions disability benefits, filing a claim for disability benefits or about a claim denial, contact the Administrative Office (see the Quick Reference Chart) to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

l. **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

a. Appeals must be in writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit to written comments, documents, records and other information relating to the claim for benefits;
- 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;
- 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.

- 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;
- 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 appropriate named fiduciary will:
  - 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
  - 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.

b. The Plan then will make a determination as follows:
   - no later than the date of the Board of Trustees meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 calendar days preceding the date of such meeting. In such case, 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.
   - 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 not later than the third meeting of the Board following the Plans' receipt of the request for review.
   - 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.
   - The Plan will notify you of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

c. 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.

d. You will receive a notice of the appeal determination. If that determination is adverse, 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);
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA section 502(a) following the appeal;
   - 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);
   - a statement of the voluntary Plan appeal procedures, if any;
   - 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;

- 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;
- 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."

e. If you do not understand English and have questions disability benefits, filing a claim for disability benefits or about a claim denial, contact the Administrative Office (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

f. This concludes the disability appeal process under this Plan. This Plan does not offer a voluntary appeal process.

How To File A Post-Service Claim and/or Life and AD&D Claim for Benefits Under This Plan

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

b. Plan benefits for post-service claims are considered for payment on the 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. Proof of death for a life insurance claim or proof of disability for an AD&D claim must be submitted.

c. If health care services are provided through the Preferred Provider Organization (PPO), the PPO Health Care Provider will usually submit the written proof of claim directly to the Appropriate Claims Administrator.

d. If you pay for non-PPO 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. Plan benefits will be paid to you up to the amount allowed by the Plan for those eligible expenses. 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.

e. **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 section) 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 name and address are listed on the Quick Reference Chart in the front of this document.
   - Complete the Employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
   - The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician, 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:
     - A description of the services or supplies provided.
     - Details of the charges for those services or supplies including CPT/CDT codes.

- Diagnosis including ICD codes.
- Date(s) the services or supplies were provided.
- Patient's name, address and date of birth.
- Insured's name, social security or ID number, and address, if different from the patient.
- Provider's name, address, phone number, professional degree or license, and federal tax identification number.

- 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.
- Complete a **claim form** once each year per family.
- 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.
- Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.
- 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.

f. In all instances, when Deductibles, Coinsurance, or Copayments apply, you are responsible for paying your share of the charges.

g. The Appropriate Claims Administrator will review your claim not later than 30 calendar days from the date it receives the claim. You will be notified if you did not properly follow the post-service/Life and AD&D claims process.

h. 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, 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.

i. 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.

j. 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.

k. The Appropriate Claims Administrator will then make a claim determination not later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.

l. **Proof of Status/Claim:**

- 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).
- 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).
- 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).
- 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.

m. 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 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.

n. **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. **If the life and AD&D claim is approved** the Plan will initiate the appropriate payment.

o. **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) on the Explanation of Benefits or EOB form. For post-service and Life and AD&D claims the notice of initial denial will:
   - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - 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;
   - 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;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - 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;
   - contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
   - 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;
   - 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
   - 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.

p. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart).
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

q. **If you disagree with a denial of a post-service or Life and AD&D claim**, you or your authorized representative may ask for an 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/Life and AD&D Claim

a. This Plan maintains a 2 level appeals process. Appeals must be 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 addresses listed on the Quick Reference Chart in the front of this document. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - 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;
   - 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 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.
   - 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;
   - 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:
     - 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
     - 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.

b. Under this Plan's 2 level appeal process, the Plan subcontracts the first level of review to the Appropriate Claims Administrator who will make the first level determination on the appeal not later than 30 calendar days from receipt of the appeal.

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

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

e. If still dissatisfied with the initial appeal level determination you will have 180 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 address is listed on the Quick Reference Chart in the front of this document.

f. The Board of Trustees then will make a second level determination according to the following timeframes:
   - **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.
   - **If an appeal is filed with the Plan <u>within 30 days</u> of the next Board**, the Board review will occur no later than the second meeting following receipt of the appeal.

- 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.
- 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.

g. 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.

h. 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.

i. You will receive a notice of the appeal determination. If that determination is adverse, it will include, at each level of the appeal review:
   - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - 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;
   - 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;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - 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;
   - 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;
   - 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;
   - 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
   - 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.

j. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart).
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.

- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

k. This concludes the post-service/Life and AD&D appeal process under this Plan.

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

a. If your claim involves urgent care (as defined earlier in this section 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.

b. Urgent care claims (as defined previously in this section) may be requested by you orally or by writing to the Appropriate Claims Administrator (as defined in this Article) whose phone number and address are listed on the Quick Reference Chart in the front of this document.

c. 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.

d. 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 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. You will be notified of the Plan's benefit determination as soon as possible but **not 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.

f. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but not 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 not 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.

g. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided not later than 3 calendar days after the oral notice.

h. **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 not later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
   - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - 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;
   - 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;
   - reference the specific Plan provision(s) on which the determination is based;

- contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- 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;
- contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
- 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;
- 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
- 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.

i. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart).
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or 800-622-8780.

j. **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

a. 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 at their phone number or address listed on the Quick Reference Chart in the front of this document.

b. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - 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;
   - 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 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;

- 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;
- 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:
  - 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
  - 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.

c. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but not later than 72 hours after receipt of the appeal.

d. The notice of appeal review of an urgent care claim will be provided orally with written (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - 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 a 2nd level appeal or external review;
   - 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;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - 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;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline d, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - 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;
   - 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
   - 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.

e. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart).
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

f. This concludes the urgent care claim appeal process under this Plan.

How To File A Concurrent Claim For Benefits Under This Plan

a. If your claim involves concurrent care (as that term is defined earlier in this section), you may file the claim by writing (orally for an expedited review) to the Appropriate Claims Administrator whose phone number and address are listed on the Quick Reference Chart in the front of this document.

b. 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.

c. 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 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.

d. 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 section.

e. 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 Preservice or Post-service claim sections of this section.

f. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided not later than 3 calendar days after the oral notice.

g. **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:
   - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - 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;
   - 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;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - 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;

- contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
- 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;
- 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
- 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.

h. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart).
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

i. **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

a. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to Appropriate Claims Administrator, at their phone number or address listed on the Quick Reference Chart in the front of this document.

b. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - 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;
   - 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 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;
   - 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;

- 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 appropriate named fiduciary will:
  - 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
  - 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.

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

d. 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:
   - information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - 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;
   - 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;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - an explanation of the Plan's 2nd level appeal (if any) 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;
   - 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;
   - 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;
   - 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
   - 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.

e. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart).
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.

- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

f. This concludes the concurrent claim appeal process under this Plan. This Plan does not offer a voluntary appeal process.

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

a. A claim for pre-service (as defined in this section) must be made by a claimant or the claimant' authorized representative (as described in this section) in accordance with this Plan's claims procedures outlined in this section.

b. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion to the Appropriate Claims Administrator (as defined in this section).

c. The pre-service claim will be reviewed not later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you did not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.

d. 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 using a written Notice of Extension.

e. 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.

f. 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.

g. 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.

h. A claim determination will be made not 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 make if no additional information is received.

i. 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 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.

j. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).

k. **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:
   - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - 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;
   - 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;

- reference the specific Plan provision(s) on which the determination is based;
- contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- 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;
- contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
- 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;
- 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
- 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.

l. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart).
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 (952) 854-0795 or Toll-Free (800) 622-8780.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

m. **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

a. This Plan maintains a 2 level appeals process. Appeals must be in writing to the Appropriate Claims Administrator for the first level of appeal review and to the Plan Administrator for the second level appeal review, all of whom have their addresses listed on the Quick Reference Chart in the front of this document.

b. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - 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;
   - 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 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;

- 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;
- 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 appropriate named fiduciary will:
  - 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
  - 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.

c. Under this Plan's 2 level appeal process, the Plan subcontracts the first level of review to the Appropriate Claims Administrator who will make the first level determination on the pre-service appeal not later than 15 calendar days from receipt of the appeal.

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

e. If still dissatisfied with the initial appeal level determination you will have 180 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 address is listed on the Quick Reference Chart in the front of this document.

f. A second level determination will be made not later than 15 calendar days from receipt of the second level appeal.

g. 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.

h. 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.

i. You will receive a notice of the appeal determination. If that determination is adverse, it will include, at each level of the appeal review:
   - information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - 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;
   - 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;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

- 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;
- 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;
- 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;
- 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
- 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.

j. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart).
   - SPANISH (Español): Para obtener asistencia en Español, llame al (952) 854-0795 or Toll-Free (800) 622-8780.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (952) 854-0795 or Toll-Free (800) 622-8780.
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   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (952) 854-0795 or Toll-Free (800) 622-8780.

k. This concludes the pre-service appeal process under this Plan. This Plan does not offer a voluntary appeal process.

The following chart outlines the timeframes for the claim filing and claim appeal process:

Overview of Claims and Appeals Timeframes					
	Urgent	**Concurrent**	**Pre-service**	**Post-service, Life and AD&D**	**Disability**
Plan must make **Initial Claim Benefit Determination** as soon as possible but not later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days	45 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.
Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but not later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days for each level	30 days for the first level and at the Board meeting for level 2.	within the timeframe for Board meetings
Second Appeal Review must be submitted to the Plan within:	NA	NA	180 days	180 days	180 days
Extension permitted during appeal review?	No	No	No	No	Yes

[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, Life and AD&D and Disability Appeal Time Frames 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 not 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, including a claim under the HRA plan, 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.

   (c) The denial is related to an emergency service, non-emergency service provided by an Out-of-Network provider at an In-Network Health Care Facility, and/or air ambulance services, as covered under the federal No Surprises Act.

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, weekly disability or "excepted/limited scope benefits" like the dental plan and vision plan. 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 a Claim Appeal Benefit Determination. 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;

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, 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 the 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

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
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
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. 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. (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.)

In addition, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than 3 years after the end of the year in which health care services were provided or, if the claim is for short term disability benefits, more than 3 years after the start of the disability.

Discretionary Authority Of Plan Administrator And Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees, and other fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. 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.

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.

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.

REMINDER ABOUT COBRA CONTINUATION COVERAGE

This Plan is bound by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and affords participants and beneficiaries the right to make self-payments to temporarily continue coverage when it might otherwise end. You will receive a general notice of your rights under the self-pay provisions separate and apart from this booklet.

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. 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. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. 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 plan within 30 days, even if that plan generally does not accept late enrollees.

The Plan rules describing self-payments are found in Article II in this booklet. Please refer to these provisions or contact the Administrative Office of the Fund for further details.

REMINDER ABOUT BEING A WISE HEALTHCARE CONSUMER

How can I be a wise consumer of health care and get the most value out of the Medical Plan?

- ✓ **Use In-Network (PPO) providers.** They charge less, and you pay less. And, Preventive Care is free when provided by In-Network PPO providers.
- ✓ **Choose Generic drugs when possible.** Ask your Doctor if a generic drug is appropriate for you.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends for you. Make medication compliance your habit to a healthier life.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range) and to stay current on recommended immunizations and cancer screening tests.
- ✓ **Not feeling well?** Call your In-Network Doctor's office for help. Or, use an In-Network Urgent Care facility instead of an emergency room (ER), if medically appropriate.
- ✓ **Precertify** your elective hospital admission, MRI, CT, PET scans, and certain other services, as explained in the Utilization Management chapter, to help avoid a financial penalty.
- ✓ **Something on a medical bill just doesn't look right?** Contact the Administrative Office if you think there might be an error on a bill.

These tips will help you make the most of your medical plan benefits.

BENEFIT RULES

The following pages set forth the Benefit Rules as of January 1, 2025

PLAN ELIGIBILITY CHART, PLAN BENEFITS CHART AND SCHEDULES

The **Plan Eligibility Chart** on the following page notes, by letter specific to each Plan, the various groups of employees who are able to participate in the benefits of the Fund. The Plan Eligibility Chart also details the eligibility standards for each of these lettered Plans. Individual eligibility is governed by Article II of this document read in conjunction with this Plan Eligibility Chart.

The **Plan Benefits Chart** on the following page notes which specific Plan benefits, as detailed in Articles III through VII of this document, apply to each of the lettered Plans.

The Schedules following the Plan Eligibility Chart and Plan Benefits Chart summarize the Life, AD&D, Disability Income, Medical, Dental and Vision benefits provided by the Fund.

Eligibility for specific benefits is governed by Article II of this document read in conjunction with the Plan Eligibility Chart and Plan Benefits Chart.

TIME LIMIT FOR INITIAL FILING OF ANY CLAIMS

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

No Plan benefits will be paid for any claim not submitted within this period.

PLAN ELIGIBILITY CHART			
Plan	Plan A	Plan A	Plan C
Region	Arizona, Colorado, Florida, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania Tennessee, Texas, and Vermont	Iowa, Missouri, Oklahoma, and Utah	Nevada
Active Employee Initial Eligiblity Start Date	The first day of the second calendar month following a period of no more than three (3) consecutive calendar months during which the active employee has worked and the Fund has received contributions for the minimum hours noted below.		
Active Employee Minimum Hours for Initial Eligibility	330 hours	330 hours	240 hours
Hour Bank Maximum	330 hours	550 hours	360 hours
Monthly Eligibility Requirement	110 hours	110 hours	120 hours
Hour Bank Extension while disabled for at least 30 days	Eligibility continues from the 1st day of the month in which the disability begins until the earlier of the 1st day of the month following the month in which the disability ends or the last day of the 3rd month of the disability.		Eligibility continues from the 1st day of the month in which the disability begins until the earlier of the 1st day of the month following the month in which the disability ends or the last day of the 6th month of the disability.
Non-Job Site Employee Eligibility	First day of the 2nd month following the date the employer signed a Participating Agreement to include non-jobsite Employees provided they work at least 30 hours/week.		

PLAN BENEFITS CHART An "X" below indicates which benefits are applicable to each Plan.			
Plan	Plan A	Plan A	Plan C
Region	Arizona, Colorado, Florida, Kansas, Louisiana, Nebraska, New Mexico, Tennessee, Texas, and Vermont	Iowa, Missouri, Oklahoma, and Utah	Nevada
Roofers Medical Plan	X	X	X
Roofers Dental Plan	X	X	X
Roofers Vision Plan	X	X	X
Employee Disability Income Benefits	X 26 wks max.	X 26 wks max.	X 26 wks max.
Employee Life & AD&D	X	X	X (effective 2-1-17)
Dependent Life	X	X	X (effective 2-1-17)

SCHEDULE OF LIFE, AD&D AND DISABILITY INCOME BENEFITS

This schedule outlines your Life, Accidental Death and Dismemberment (AD&D) and Disability Income (DI) benefits. See Article III for more information.

Benefit Description	Benefits Applicable to Plans As Shown Below	
	Plan A	Plan C
Employee's Life Coverage	$10,000	$10,000
Dependent's Life Coverage • (only if Employee Life Coverage is in effect) Spouse: Children: 14 days to 19 years: Children: 19 years of age, to age 26:	 $500 $100 $100	 $500 $100 $100
Employee's Accidental Death and Dismemberment Coverage Principal Sum:	$10,000	$10,000
Employee's Disability Income Benefit • Maximum Weekly Benefit: • Benefits begin first day injury or 7th day of sickness. • Maximum Benefit Period is 26 weeks. • Only employees are eligible for the weekly disability benefit. • Includes maternity leave. Maternity disability will be effective once a physician determines an employee should not be working.	$400	$400 for commercial only.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
DEDUCTIBLE (CALENDAR YEAR) • Copayments and non-eligible expenses are not used to satisfy a Deductible. • Deductible Carryover provision is discussed in the Medical Benefits Article. • The annual deductible does not apply to preventive/wellness serivces or to outpatient retail and mail order drugs.	$400 per person $1,200 per family	
COINSURANCE PAYABLE BY THE PLAN	The Plan Coinsurance payable after satisfaction of the Deductible is generally 80% (in-network) in Covered Expenses per person per calendar year.	The Plan Coinsurance payable after satisfaction of the Deductible is generally 50% (out-of-network) in Covered Expenses per person per calendar year.
ACCIDENT BENEFIT • Applies to doctor's treatment, medical supplies a doctor prescribes, hospital confinement, x-rays, lab tests, care by a RN or therapist, ambulance, or oxygen. • Does not apply to eye refractions, frames, lenses, contacts or their fittings or dental treatment (except for Accidental Injury to Teeth).	The Plan pays 100% of the eligible charges for the first $300 of Covered Expenses that are incurred within 90 days from an accident; thereafter, normal plan cost-sharing (deductible, copay, coinsurance) applies.	

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
PRE-ADMISSION REVIEW (PRECERTIFICATION) AND AUTHORIZATION The following services must be precertified to avoid a financial penalty, by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document. a. All Elective inpatient hospital admissions*, including transplants; *Note: precertification is required only for pregnant women with inpatient hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section. b. Outpatient radiology imaging studies like CT, MRI, PET scans; c. Residential treatment program admission; d. Skilled nursing facility admission; e. Inpatient rehabilitation or habilitation facility admission; f. Inpatient hospice facility admission; g. Experimental or investigational services including routine costs associated with a clinical trial; h. Injectable drugs like Botox, Immune Globulin, Interferon & Antihemophilic factor; i. Spinal procedures, including all inpatient and outpatient spinal procedures if they are performed at a hospital or outpatient ambulatory surgical facility/center. j. Administration of a class of drugs called "survival motor neuron-2 (SMN2)-directed antisense oligonucleotides," which includes drugs such as Spinraza (nusinersen). k. Any technique that uses genes to treat or prevent disease (gene therapy) including but not limited to Kymriah, Yescarta, Luxtuma, etc. • For emergency admissions, the UM Company must be notified of that inpatient admission within 48 hours of the admission. • Certain outpatient drugs require precertification by contacting the Prescription Drug Program (contact information on the Quick Reference Chart).	An additional $250 penalty will apply if authorization is not obtained as required by the Plan. Failure to precertify survival motor neuron-2 or Gene Therapy will result in no benefits being payable for those treatments. The penalty for failure to precertify does not accumulate to a Deductible or Out-of-Pocket Limit.	

OUT-OF-POCKET LIMIT (Annual Limit on In-Network Cost Sharing) The Medical Plan has an **Out-of-Pocket Limit** which limits your annual cost-sharing for covered essential health benefits received from in-network providers related to Medical Plan deductibles, coinsurance, and copayment. The Out-of-Pocket Limit is the most you pay in deductibles, coinsurance, and copayments during a one-year period (the calendar year) before your health plan starts to pay 100% for covered essential health benefits received from in-network providers. The Amount of the annual Out-of-Pocket Limit is explained to the right. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • 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. • Medical Plan expenses and Outpatient retail and mail order drug expenses accumulate to meet separate Out-of-Pocket Limits. See the Drug row in this Schedule for the Outpatient Drug Limit. The Out-of-Pocket Limit does not include or accumulate: 1) Premiums and/or contributions for coverage, 2) Expenses for medical services or supplies that are not covered by the Plan, 3) Except in the case of No Surprises Act Services, charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for Out-of-Network providers 4) Penalties for non-compliance with Utilization Management program requirements, 5) Charges in excess of the Medical Plan's maximum benefits, 6) Expenses for the use of Out-of-Network providers, except emergency services, non-emergency services from an Out-of-Network provider at an In-Network facility, and/or air ambulance services, 7) Expenses that are <u>not</u> considered to be essential health benefits, such as TMJ syndrome treatment, and infertility treatment, 8) Expenses for brand name drugs when generics are available. 9) Dental Plan and Vision Plan expenses.	Medical Plan: $5,000 per person $10,000 per family Outpatient Retail and Mail Order Drugs: $1,600 per person $3,200 per family	Unlimited. There is no Out-of-Pocket Limit on the use of Out-of-Network providers, except that emergency services, non-emergency services from an Out-of-Network provider at an In-Network facility, and air ambulance services will accumulate to meet the in-network Out-of-Pocket Limit.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
AMBULANCE • Ground vehicle transportation to the nearest appropriate facility as medically necessary for treatment of an Emergency Medical Condition, acute illness or necessary inter-health care facility transfer. • Air/sea transportation is payable: (1) only when Medically Necessary for treatment of a life-threatening Emergency Medical Condition, and (2) the air/sea transport is required because of inaccessibility by ground transport and/or the use of ground transport would endanger the patient's health status. When air/sea ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's emergency condition. • Non-emergency medical transportation services are not payable by this Plan unless those travel expenses are related to a Plan-approved transplant as outlined under Transplantation in the Schedule of Medical Benefits or are provided under an approved alternate care plan in conjunction with case management.	80% after Deductible met.	
AMBULATORY SURGICAL CARE FACILITY/CENTER (OUTPATIENT SURGERY FACILITY) • Ambulatory (Outpatient) Surgical Facility/Center is also called a surgicenter, or same day surgery. • Physician fees payable under the Physician services row of this Schedule of Medical Benefits. • Certain services like spinal procedures, including all inpatient and outpatient spinal procedures if they are performed at a hospital or outpatient ambulatory surgical facility/center require precertification by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.	Facility Fees: 80% after Deductible met.	Facility Fees: 50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
BEHAVIORAL HEALTH SERVICES (includes Mental Health and/or Substance Abuse Treatment) • Office visits. • Outpatient services including intensive outpatient treatment program and partial day treatment. • Inpatient hospital admission. • Residential treatment program admission (for in-network providers only). • Applied Behavior Analysis (ABA) Therapy. • Admission to an inpatient facility or residential treatment program must be precertified to avoid a financial penalty. Contact the Utilization Management Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.	Office visit charge for Primary Care Physician or Specialist: $20 copay per office visit, no Deductible. All other services performed and billed during an office visit the Plan pays 80% after deductible met. Outpatient, (including but not limited to ABA therapy), Inpatient, Partial day treatment, Intensive outpatient treatment program, and Residential Treatment Program: 80% after Deductible met.	Office visit charge: 50% after Deductible met Outpatient, Inpatient, Partial day treatment, and Intensive outpatient treatement program: 50% after Deductible met. Residential Treatment Program: Not covered.
BLOOD • Blood transfusion, blood products, and supplies for administration.	80% after Deductible met.	50% after Deductible met.
CHEMOTHERAPY	Facility and Professional fees: 80% after Deductible met.	Facility and Professional fees: 50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
CHIROPRACTIC SERVICES • Maximum benefit is 12 visits per person per calendar year in- or out-of-network.	Office visit charge: $20 copay per office visit, no Deductible. All other services performed and billed during an office visit the Plan pays 80% after Deductible met.	Professional fees: 50% after Deductible met.
CORRECTIVE APPLIANCES (PROSTHETIC & ORTHOTIC DEVICES, OTHER THAN DENTAL) • Orthotic Devices to support a weakened body part such as casts, splints, trusses (also called a binder), braces and crutches; a) rental (but only up to the allowed purchase price of the device); b) purchase of standard models at the option of the Plan; c) repair, adjustment or servicing of the device or replacement of the device due to a change in the Eligible Person's physical condition or if the device cannot be satisfactorily repaired. d) Foot Orthotics (orthopedic or corrective shoes and other supportive appliances for the feet) one pair is payable once every 4 years for adults and once in a period of 6 months for children under age 19 when replacement is required due to growth. • Prosthetic Devices to replace a missing body part such as artificial limbs and eyes, and prostheses following mastectomy, including their necessary replacements or repair. Cochlear implant device is payable when medically necessary.	80% after Deductible met.	50% after Deductible met.
DIABETES EDUCATION • Coverage is payable for a formal diabetes education course/program taught by a Certified Diabetes Educator and recognized as an acceptable program by the American Diabetes Association. • A diabetes education program is payable when a person is initially diagnosed with diabetes or pre-diabetes. • A refresher course is payable once each year for up to 5 times.	No charge	50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
DIALYSIS • 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.	Facility and Professional fees: 80% after Deductible met.	Facility and Professional fees: 50% after Deductible met.

DRUGS: OUTPATIENT RETAIL AND MAIL ORDER PRESCRIPTIONS	
• 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. Benefits for outpatient 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. • Participants may obtain diabetics care supplies (e.g. insulin syringes, blood glucose meter test strips, lancets) from the retail pharmacy. • Retail Drugs: To obtain up to a 30-day supply of medication for the cost-sharing noted to the right, present your ID card to any in-network retail pharmacy. You can find the location of in-network retail pharmacies by contacting the Prescription Drug Program (see the Quick Reference Chart). If the cash price of the drug is less than the applicable copay or coinsurance, you will pay the cash price for the drug. • 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. Note that not all medicines are available via mail order. Check with the Prescription Drug Program for further information. To use the mail order service: • Have your doctor write the prescription for up to a 90-day supply, with the appropriate refills. • Mail your prescription, copay and the 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. • *The Plan provides a mandatory generic program, meaning that if a brand name drug is dispensed in place of a generic, regardless if you or your doctor request it, you will pay the brand cost-sharing plus the difference in cost between the generic and brand name drug.* • *Copayments and coinsurance for Non-preferred Brand, Preferred Brand, and Specialty Brand drugs only apply if there is no generic equivalent available.* • Contact the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document) for information on the formulary Performance Drug List and for the following: • Information on medication requiring prior authorization (precertification) by the clinical staff of the Prescription Drug Program, such as specialty drugs and compounded medication. • Information on which medications have a limit to the quantity payable by this Plan, such as certain migraine treatments and other pain medications. Information on which drugs are part of the step therapy program where you first try a proven, cost-effective generic medication before moving to a more costly brand-name drug treatment option, such as medication to treat high cholesterol, stomach ulcers, and pain. • The Plan offers a 90-day supply of medication at certain CIGNA-approved 90-day Retail pharmacy locations, including CVS, Target, Walmart, and Kroger/Frys. You pay the same as you would for a 90-day Mail Order medication supply. More information about the 90-day at retail program is provided at Cigna.com/Rx90network. The 90-day at retail program does not apply to Specialty drugs which are available in up to a 30-day supply. • Copayments and Coinsurance for Retail and Mail Order drugs are not applied to meet the Plan's Deductibles, but cost-sharing for outpatient drugs does accumulate to meet the annual Out-of-Pocket Limit for outpatient drugs. • Specialty drugs are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are used by individuals with unique health concerns and include items such as	No medical plan deductible applies to outpatient drug benefits. In-Network Retail Pharmacy (up to a 30-day supply) Generic: $5.00 or 25%, whichever is greater Preferred Brand: $20.00 or 25% (if no generic is available) whichever is greater Non-Preferred Brand: $40 or 50% whichever is greater (if no generic is available) 90-day supply at Retail or Mail Order (Home Delivery) Service (up to a 90-day supply) Generic: $10.00 copay Preferred Brand: $40.00 copay (if no generic is available) Non-Preferred Brand: $80.00 copay (if no generic is available) Specialty Drugs (up to a 30-day supply) Generic: You pay a 5% coinsurance to a maximum of $75 per prescription Brand: You pay a 5% coinsurance to a maximum of $150 per prescription (if no generic is available) 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 Drug Program as listed on the Quick Reference Chart. For eligible prescriptions, you will be reimbursed the billed charges minus the appropriate cost-sharing. The annual Out-of-Pocket Limit on outpatient drugs is the most you pay each calendar year for covered generic, preferred brand, non-preferred brand and specialty drugs from in-network retail and mail order locations: $1,600/person/calendar year $3,200/family/calendar year (these amounts will be adjusted in accordance with law).

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
injectables for multiple sclerosis, rheumatoid arthritis, or hepatitis. These drugs require prior authorization and are managed because they often require special handling, are date sensitive and are usually available only in a 30-day quantity. Contact the Prescription Drug Program at their phone number on the Quick Reference Chart in the front of this document. • No Cost Drugs: The Plan provides coverage for certain drugs purchased at a retail pharmacy consistent with the A and B recommendations of the US Preventive Task Force. See Section J of Article V-A for preventive drug information. Where information in this document conflicts with newly released Affordable Care Act regulations affecting the coverage of certain preventive drugs, this Plan will follow the new requirements on the date required. • Immunizations are payable at a retail pharmacy location at no charge. • Drugs that have not yet been approved by the FDA are not covered. New FDA-approved drugs will be covered by the Plan unless stated otherwise.		
DURABLE MEDICAL EQUIPMENT (DME) • Coverage is provided for equipment that meets the definition of Durable Medical Equipment, and its use is medically necessary and is ordered by a Physician or Health Care Practitioner, as follows: 1) Rental (but only up to the allowed purchase price of the DME); 2) Purchase of standard models at the option of the Plan; 3) Repair, adjustment or servicing or medically necessary replacement of the Durable Medical Equipment due to a change in the Eligible Person's physical condition or if the equipment cannot be satisfactorily repaired; 4) Coverage is provided for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration; 5) Insulin pumps and blood glucose testing devices are considered payable durable medical equipment under this Plan. See the Drugs: Outpatient Retail and Mail Order Prescriptions row in this Schedule of Medical Benefits for information on supplies needed to operate these devices; 6) For the first 12 months following the birth of a child, coverage is provided for one standard manual or standard electric breast pump, plus breast pump supplies needed to operate the breast pump. Rental, purchase and repair is payable as outlined above. No charge when obtained in-network. Reimbursement for a breast pump and supplies from a Out-of-Network provider is payable up to 50% after the deductible is met.	Breast pump and necessary supplies to operate: No charge All other covered DME: 80% after Deductible met.	50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
EMERGENCY SERVICES OR URGENT CARE FACILITY • Emergency Services for an Emergency Medical Condition (as these terms are defined in this Plan). • See also the Ambulance row of this Schedule. • Urgent Care facility. Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea or vomiting, or bladder infections. • Ancillary services (such as lab or x-ray) performed during the ER or Urgent care visit. • If you receive emergency services and the physicians delivering the care are Out-of-Network providers, your eligible expenses will be processed at the in-network level of benefits and cost-sharing will accumulate to meet the in-network annual Out-of-Pocket Limit. • Copay waived if admitted to a hospital from the emergency room or urgent care facility. • There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. Emergency services are covered: • Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis; • Without regard to whether the health care provider furnishing the emergency services is a Network provider or a Network emergency facility, as applicable, with respect to the services; • Without imposing any administrative requirement or limitation on Out-of-Network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from In-Network providers and In-Network emergency facilities; • Without imposing cost-sharing requirements on Out-of-Network emergency services that are greater than the requirements that would apply if the services were provided by an In-Network provider or an In-Network emergency facility; • By calculating the cost-sharing requirement for Out-of-Network emergency services as if the total amount that would have been charged for the services were equal to the recognized amount for the services; and	Emergency Facility and Professional fees: After deductible met and you pay a $250 copay per visit, the Plan pays 80% coinsurance. Urgent Care Facility: After deductible met and you pay a $100 copay per visit, the Plan pays 80% coinsurance.	Emergency Facility and Professional fees: After deductible met and you pay a $250 copay per visit, the Plan pays 80% coinsurance. Urgent Care Facility: 50% coinsurance after deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
• By counting any cost-sharing payments made by the participant or beneficiary with respect to the emergency services toward any In-Network deductible or In-Network out-of- pocket maximums applied under the plan (and the In-Network deductible and In-Network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by an In-Network provider or an In-Network emergency facility. Emergency services furnished by an Out-of-Network provider or an Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until: • The provider or facility determines that the patient or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and • The patient or beneficiary is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network providers listed; and • The patient, beneficiary or patient's authorized representative gives informed consent to continued treatment by the Out-of-Network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-Network provider may result in greater cost to the participant or beneficiary.		
FAMILY PLANNING • Surgical sterilization is covered. No charge for female sterilization performed in-network. • FDA-approved contraceptives for females are covered, at no cost from in-network providers, such as oral birth control pills/patch, contraceptive injections such as Depo-Provera/Lunelle, intrauterine device (IUD), diaphragm, or an implantable birth control device are covered. Some contraceptives are payable under the Retail/Mail Order Prescription Drug benefit. • Contraceptive counseling and education for females is payable at no cost from in-network providers. • For fertility diagnosis and treatment, after the deductible is met the first $10,000 per couple per lifetime is payable at the usual coinsurance in-network or out-of-network; thereafter, the Plan pays 10% not subject to the annual out-of-pocket limit. • See also the Medical Exclusions Article.	Female sterilization and contraceptive services: No charge. All other Facility and Professional fees: 80% after Deductible met.	Facility and Professional fees: 50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Gene Therapy (Human) • A technique designed to introduce human genetic material into human cells to compensate for abnormal genes or to make a beneficial protein, used to treat or prevent disease in humans. • Gene therapy requires precertification to avoid a non-payment penalty by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.	Facility and Professional fees: 80% after Deductible met	Facility and Professional fees: 50% after Deductible met.

GENETIC TESTING AND COUNSELING • Medically necessary genetic testing payable under this Plan is for: 1) state-mandated newborn screening tests for genetic disorders; 2) 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; 3) tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; 4) genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis; 5) genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see the Preventive services row in this Schedule of Medical Benefits). 6) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if all the following conditions are met: • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and • the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and • the results of the test will directly impact clinical decision-making, outcome or treatment being delivered to the covered individual. • Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by this Plan. • No coverage for pre-parental genetic testing (also called carrier 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 individuals who are not covered under this Plan. Genetic testing costs may be covered for a non-covered individual only if such testing would directly impact the treatment of a covered plan participant. • Plan participants should use the Plan's precertification procedure or contact the Administrative Office to assist in determining if a proposed genetic test will be covered or excluded.	Facility and Professional fees: 80% after Deductible met.	Facility and Professional fees: 50% after Deductible met.
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.	80% after Deductible met.	50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
• Home health aide services are covered if provided for the direct care of the patient and the services are intermittent and part-time (duration not to exceed 16 hours/day typically on less than a daily basis). • The annual maximum benefit for Skilled Nursing Care services and supplies to provide Home Health Care and home infusion service is 100 visits per person. Medication administered by infusion is not subject to this maximum.		
HOSPICE • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the definition of hospice in the Definitions Article. • Inpatient hospice admission requires precertification to avoid a financial penalty, by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.	Home Hospice and Inpatient Hospice Facility and Professional fees: 80% after Deductible met.	Home Hospice: 50% after Deductible met. Inpatient Hospice Facility: Not covered.
HOSPITAL SERVICES (INPATIENT) • All Elective inpatient hospital admissions, including transplants and spinal procedures, require precertification to avoid a financial penalty, by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document. • Hospital room & board (including general nursing services). Private room is covered only if medically necessary or if the facility does not provide semi-private rooms. • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related medically necessary ancillary services (e.g., prescriptions, supplies). • Newborn care. See the Eligibility Article for how to properly enroll Newborns so coverage can be considered.	Facility Fees: 80% after Deductible met.	Facility Fees: 50% after Deductible met.
LABORATORY (OUTPATIENT/OFFICE) • Includes pre-admission testing.	Facility and Professional fees: 80% after Deductible met.	Facility and Professional fees: 50% after Deductible met.
MAMMOGRAPHY See the Preventive Services row for information on screening mammography.		

MATERNITY SERVICES • Hospital and Birth (Birthing) Center charges and Physician and Midwife fees for medically necessary maternity services. • For all females, prenatal and postnatal office visits obtained from an in-network provider are payable at no cost to you. Normal plan cost-sharing applies to all other maternity related services including ultrasounds and delivery fees. When an in-network provider submits a bill to the plan with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses. • Prenatal/postnatal office visits and Health Reform mandated preventive services are covered for a pregnant dependent child. No coverage is provided for prenatal ultrasounds or delivery expenses of pregnant Dependent children, unless the services are considered Emergency Services. • 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 caesarean section. Charges for hospitalization for a mother and newborn following childbirth of at least 48 hours for a vaginal delivery and 96 hours for a caesarean delivery. The length of stay begins at the time of delivery if the delivery takes place in a Hospital. If the delivery does not take place in a Hospital, the length of stay begins once the mother and newborn are admitted to the Hospital as inpatients. The mother and newborn are not required to stay 48/96 hours if the attending provider, after consulting with the mother, decides to discharge the mother and newborn earlier. • Authorization is required for a maternity stay that exceeds the standard stay (standard stay is up to 48 hours following a vaginal delivery and 96 hours following a caesarean section). Such Authorization must be obtained from the Utilization Management Company within 48 hours of expiration of the standard stay. • 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 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. • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable (while breastfeeding) as noted on the Durable Medical Equipment row of this Schedule. • The Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider while breastfeeding, at 100%, no deductible, when provided by an in-network provider.	Prenatal and postnatal office visits, lactation counseling and Health Reform mandated preventive services for pregnant females: No charge All other covered services Facility and Professional fees: 80% after Deductible met.	Facility and Professional fees: 50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
• While obstetrical ultrasounds may be part of routine prenatal care, normal radiology cost-sharing applies to ultrasound services. See the Physician and Other Health Care Practitioners row and the Radiology row of this Schedule.		

NON-DURABLE SUPPLIES
• Coverage is provided for medically necessary non-durable supplies dispensed and used by a Physician or health care practitioner in conjunction with treatment of the covered individual. Non-durable means 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, plastic tubing, cleansing solutions, etc.
• Coverage is provided for up to a 31-day supply of home/personal use non-durable supplies in these situations:
  • 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) are covered under the Drugs: Outpatient Retail and Mail Order Prescriptions section of this Article.
	80% after Deductible met	50% after Deductible met.

NUTRITIONAL COUNSELING • In accordance with Health Reform, for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors the Plan covers Physician-prescribed intensive behavioral counseling interventions to promote a healthful diet and physical activity for cardiovascular disease prevention.	No charge	50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS

PHYSICIAN AND OTHER HEALTH CARE PRACTITIONERS
• Certain services require precertification to avoid a financial penalty, by contacting the Utilization Management Company (see the Quick Reference Chart for contact information). For more information, see the Utilization Management Program section toward the front of this document.
• Benefits are payable when provided by a Physician or other covered Health Care Practitioner in an office, hospital, emergency room, or other covered health care facility location.
• Professionals payable by this Plan include:
  • Physician (MD, DO);
  • Surgeon; Pathologist; Radiologist; Podiatrist;
  • Assistant surgeon, including Physician, Physician Assistant (PA), Certified Surgical Assistant, and Registered Nurse are payable if medically necessary.
  • Anesthesia provided by Physicians and Certified Registered Nurse Anesthetists (CRNA);
  • Physician Assistant; Nurse Practitioner; Nurse Midwife;
• Second Surgical Opinion.
• See the discussion of "Surgery" in the Medical Benefits Article.
• Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
• 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.
	Office Visit charge for Primary Care Physician or Specialist:
	$20 copay per office visit, no Deductible.
	
	All other services performed and billed during an office visit:
	80% after deductible met.
	
	All other Professional fees:
	80% after Deductible met.
		Professional fees:
		50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
PREVENTIVE SERVICES FOR CHILDREN AND ADULTS: The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control and Prevention (CDC). These websites (periodically updated) list the types of payable preventive services (such as immunizations, mammogram, pap smear, colonoscopy with polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index. 1) 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. Preventive services are those services performed for screening purposes when the individual does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the individual has a condition or an active symptom of a condition. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive. 2) If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. If there is no network provider who can provide the Health Reform required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. 3) 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 deductible/copay/coinsurance. Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions.	No charge	50% after Deductible met
RADIOLOGY (X-RAYS), NUCLEAR MEDICINE, RADIATION THERAPY (OUTPATIENT/OFFICE) • Includes pre-admission testing. • Outpatient radiology imaging studies like CT, MRI and PET scan require precertification to avoid a financial penalty, by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.	Facility and Professional fees: 80% after Deductible met.	Facility and Professional fees: 50% after Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS

RECONSTRUCTIVE SERVICES AND BREAST RECONSTRUCTION AFTER MASTECTOMY
• This Plan complies with the Women's Health and Cancer Rights Act that indicates that for any Eligible Person 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 for the following:
  • 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.
• Other reconstructive surgery is payable only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, congenital anomaly that causes a functional defect, or results from a prior covered therapeutic procedure.
	Facility and Professional fees:
	80% after
	Deductible met.
		Facility and Professional fees:
		50% after
		Deductible met.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
REHABILITATION AND HABILITATION THERAPY SERVICES (PHYSICAL, OCCUPATIONAL & SPEECH THERAPY; CARDIAC & PULMONARY REHABILITATION) • Short term active, progressive Rehabilitation or Habilitation Therapy Services (Occupational, Physical, or Speech Therapy) are payable when performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation or Habilitation Services in an acute Hospital, rehabilitation or habilitation unit or facility or Skilled Nursing Facility are payable for short term, active, progressive Rehabilitation or Habilitation Therapy Services that cannot be provided in an outpatient or home setting. ▪ Inpatient rehabilitation or habilitation facility admission requires precertification to avoid a financial penalty, by contacting the Utilization Management Company (see the Quick Reference Chart for contact information). See also the Utilization Management section toward the front of this document. • Medically necessary speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist. • Maintenance rehabilitation and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation in the Medical Exclusions Article. See the definition of Rehabilitation Therapy Services in the Definitions Article. • Other Rehabilitation Services (Cardiac & Pulmonary Rehabilitation) are payable under the supervision of qualified medical personnel capable of treating cardiac or pulmonary emergencies as provided in a hospital outpatient department or other outpatient setting.	Facility and Professional fees: 80% after Deductible met. Habilitation visits: Outpatient: 60 visits/person per calendar year. Habilitation Inpatient: admission: 60 days/person per calendar year. Visit limits will not apply to diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.	Outpatient Facility and Professional fees: 50% after Deductible met. Inpatient rehabilitation admission expenses, including Skilled Nursing Facility: Not covered.

SCHEDULE OF MEDICAL BENEFITS

This schedule outlines the Medical Benefits payable by the Plan for enrollees in Plan A and Plan C. See also Articles I, V-A and V-B for more information.

IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge, as defined in Article I Definitions, and could result in balance billing to you, except in the case of No Surprises Act Services.

BENEFIT DESCRIPTION	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
SKILLED NURSING FACILITY (SNF) AND SUBACUTE FACILITY • Services must be ordered by a Physician. • Skilled Nursing Facility and Subacute Facility confinement payable up to 60 days per person per calendar year, for either skilled or subacute care. Subacute facility also called Long Term Acute Care (LTAC) facility. • Admission to a Skilled Nursing Facility requires precertification to avoid a financial penalty, by contacting the Utilization Management Company (see the Quick Reference Chart for contact information). See also the Utilization Management section toward the front of this document.	80% after Deductible met.	Not covered.
TMJ SYNDROME/DYSFUNCTION SERVICES • The first $500 for non-surgical services per person per calendar year or $1,500 for surgical services per person per calendar year is payable at the usual coinsurance after the deductible is met, in or out-of-network; thereafter, the Plan pays 10% of eligible expenses and these eligible expenses do not apply to the Plan's out-of-pocket limit.	Office Visit charge: $20 copay/visit, no deductible. All other Facility and Professional fees: 80% after Deductible met.	Facility and Professional fees: 50% after Deductible met.

TRANSPLANT: HUMAN ORGAN AND TISSUE • Transplant services (human organ and tissue) are payable in-network or out-of-network according to this chart. • Transplant services including pre-transplant workup tests require precertification by calling the Utilization Management (UM) Company at their phone number listed on the Quick Reference Chart in the front of this document. For more information, see the Utilization Management Program section toward the front of this document. The UM Company can also tell you the location of the In-Network Transplant Centers of Excellence. • Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue (including bone marrow, stem cells, cornea), heart, intestine, kidney, liver, lung(s), or pancreas, along with the facility and professional services, FDA approved drugs, and medically necessary equipment and supplies. See also the definition of "medically necessary" in the Definitions Article. • Benefits are also payable for 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, are payable without any Deductibles and Coinsurance applicable to those donor expenses. Reasonable and necessary expenses incurred by a donor who is not covered by this Plan, are payable but only to the extent the donor is not covered by the donor's own insurance or health care plan. Reimbursement for in-network donor expenses is at 100% without any Deductibles and Coinsurance applicable to those donor expenses. • Transplant-related travel benefits for a transplant recipient who needs to travel to an in-network transplant facility that is more than 100 miles from their residence, are payable only when pre-approved by the Utilization Management Company and when using in-network providers, as follows: • Transplant-related travel expenses, including transportation and lodging (up to $50 per person per day) for the patient and one family member or companion (and as needed for a live donor) are payable (reimbursable) to a maximum of $10,000 per transplant. Reimbursement is available for round trip "coach" airfare to travel to/from the transplant facility, and up to a maximum of $50 per day for lodging received during the pre-operative work-up, transplant operation, and post-transplant treatment phases. Receipts are required when submitting lodging and travel expenses for payment consideration. The following expenses will not be reimbursed by the Plan: meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and expenses for persons other than the patient and his/her designated family member/travel companion. No travel benefit for use of out-of-network providers.	Office Visit charge: $20 copay per visit, no deductible. All other Facility and Professional fees: 80% after Deductible met. Reimbursement for Travel expenses: 100% up to the benefit max. See also the travel benefits as outlined to the left.	Donor, Facility and Professional fees: The first $50,000 of eligible transplant expenses performed Out-of-Network are paid at 50% after the deductible is met thereafter, the Plan pays 10% of eligible expenses. NOTE: Out-of-Network charges do not apply toward the out-of-pocket limit. No travel benefit for use of out-of-network providers.
WELLNESS BENEFITS See the Preventive Services row in this Schedule.		

SCHEDULE OF DENTAL BENEFITS

This schedule outlines the benefits payable by the Dental Plan. See also Article VI for more information. You may use any licensed Dental provider as there is no contracted Dental Network. Estimates for dental treatment that exceed $300 should be filed with the Administrative Office.

ANNUAL DENTAL MAXIMUM BENEFIT	Plan A: $1,000 per person per calendar year Plan C: $1,500 per person per calendar year
DENTAL PLAN DEDUCTIBLE (ANNUAL CALENDAR YEAR) • All benefits except preventive/diagnostic services are subject to the Dental Plan Deductible.	$100 per individual per calendar year $300 per family per calendar year
PREVENTIVE/DIAGNOSTIC SERVICES	100% of the Allowed Charge, no deductible applies
BASIC SERVICES	80% of the Allowed Charge after deductible met
MAJOR SERVICES	80% of the Allowed Charge after deductible met

SCHEDULE OF VISION BENEFITS

This schedule outlines the benefits payable by the Vision Plan. See also Article VII for more information. You may use any licensed optical provider as there is no contracted optical/vision network. Benefits are not subject to a Deductible.

Benefit Description		All Plans
EYE EXAMS • One exam per 12 consecutive months for individuals 18 years and older. • One exam per 12 consecutive months for individuals under 18 years.	Exam for individuals 18 years and older: Exam for individuals under 18 years:	100% up to $32.50 100%
FRAMES FOR PRESCRIPTION GLASSES • One frame per person per 24 consecutive months.	Frame:	100% up to $50

LENSES
• Not more than one pair in 12 months.
• Contacts: Are payable when:
  • Medically necessary after cataract surgery or if vision cannot be corrected to 20/70 without such lenses; or
  • For cosmetic purposes.
	Single Vision:
	Bifocal:
	Trifocal:
	Lenticular:
	Medically Necessary Contact Lens:
	Cosmetic Contact Lens:
		100% up to $25.00
		100% up to $37.50
		100% up to $47.50
		100% up to $100.00
		100% up to $437.50
		100% up to $50.00

ARTICLE I: DEFINITIONS

This Article contains definitions of those terms used in more than one Article of this document. Defined terms pertaining to a specific Article are found in that Article. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Section 1. Accident – A sudden and unforeseen event as a result of an external or extrinsic source.

Section 2. Active Employee – The term "Active Employee" means any Employee who, by reason of his active employment under the terms of a collective bargaining agreement requiring contributions to this Fund, meets the eligibility requirements hereunder as established by the Board and as amended from time to time.

Section 3. 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.

Section 4. Administrative Office – The term "Administrative Office" means the company or firm with which the Trustees have contracted for day to day administrative services.

Section 5. Air Ambulance Services – means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Section 6. 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 Plan Participant (see also the COB 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.

Section 7. 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:

a. **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**

b. **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**

c. **For an Out-of-Network medical plan provider**, except for No-Surprises Act Services, the maximum reimbursable charge amount payable by this Plan is as follows:
   1. 150% of the Medicare-based reimbursable charge (MRC-2). If there is no applicable Medicare-based reimbursable charge for the services, the Plan will pay according to #2 below.
   2. the 50th percentile of the Allowed Charge (defined as the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services performed or supplies provided by Out-of-Network providers). If the Allowed Charge schedule is not able to be referenced, the Plan will pay according to #3 below.

   or

d. **For an Out-of-Network Dental Plan provider**, the allowed charge amount is the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary dental services or supplies.

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.

Out-of-Network - 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 and 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, except in the case of No Surprises Act Services. Other than for No Surprises Act services, participants are responsible for amounts that exceed "allowed charge" amounts by this Plan.

In the case where the PPO allowed charge amount on an eligible claim exceeds the actual billed charges, the participant and the Plan will pay their coinsurance on the lesser amount, the billed charges, and the Plan will pay the excess difference between the actual billed charges and the PPO allowed charge amount in full.**Section 8. Ambulance, Professional Ambulance Service –** means a ground motor vehicle, helicopter (rotorcraft), airplane (fixed wing) or boat that is:

a) licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and
b) is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals; and
c) provides medical transport services for persons who are seriously ill, injured, wounded, or otherwise incapacitated or helpless and in need of immediate medical transportation; or
d) are unable to be transported between health care facilities in other than an ambulance (such as transport of an inpatient between hospitals to obtain a radiology procedure or transport from a hospital to a skilled nursing facility).

Non-emergency medical services include transportation of individuals who cannot use public or private transportation because of their medically necessary requirement to be positioned in a wheelchair or stretcher. Non-emergency medical transportation services **are not** payable by this Plan unless those travel expenses are related to a Plan-approved transplant as outlined under Transplantation in the Schedule of Medical Benefits in this document or are provided under an approved alternate care plan in conjunction with case management.

Section 8. Ambulatory Surgical Facility/Center – The term "Ambulatory Surgical Facility/Center" means a specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

A. It 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; or
B. Where licensing is not required, it meets all of the following requirements:
    - It is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
    - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise and anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
    - It provides at least one operating room and at least one post-anesthesia recovery room.
    - It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
    - It has trained personnel and necessary equipment to handle emergency situations.
    - It has immediate access to a blood bank or blood supplies.
    - It provides the full-time services or one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
    - It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), and operative report and a discharge summary.

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.

Section 9. Ancillary Services – With respect to non-emergency services performed by an Out-of-network provider at in-network Health Care Facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

Section 10. 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.

Section 11. Applied Behavior Analysis (ABA) Therapy – is the design, implementation, and evaluation of environmental modifications to attempt to produce socially significant improvement in human behavior. 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. Applied Behavior Analysis Therapy is a covered benefit.

Section 12. 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 individual 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 a medical student, intern, 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).

Section 13. Balance Billing – a bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan, even if the Plan's Out-of-Pocket Limit is reached, except in the case of services subject to the No Surprises Act. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, except in the case of No Surprises Act Services, amounts exceeding the Allowed Charge do not count toward the Plan's Out-of-Pocket Limit and may result in balance billing to you. **Out-of-Network Health Care Providers commonly engage in balance billing, though they can not balance bill for services subject to the No Surprises Act**. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the plan's payment for a covered service. Generally, you can avoid balance billing by using In-Network providers. Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid balance billing by using In-Network providers.**

Section 14. Behavioral Health Disorder – 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. Behavioral health disorder includes, among other things depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Behavioral Health Practitioners as defined in this Article. Certain ,

conditions and diseases are specifically excluded from coverage as noted in the Medical Exclusions Article of this document.

Section 15. Behavioral Health Practitioners – A psychiatrist, psychologist, 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 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.

Section 16. Behavioral Health Treatment – Behavioral Health Treatment includes outpatient visits and 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 is considered a Behavioral Health Treatment for the purposes of this Plan.

Section 17. 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 fully meets one of the following two tests:

1. It 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; or
2. Where licensing is not required, it meets all of the following requirements: has at least one Physician on staff or on call and provides skilled nursing care by licensed Nurses under the direction of a full-time Registered Nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

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 transitional facility, group home, halfway house or temporary shelter is not a Behavioral Health Treatment Facility under this Plan. See also the definition of Residential Treatment Facility.

Section 18. Beneficiary – The term "Beneficiary" means any person or persons named by an Employee, other than his Employer. If a Beneficiary is not named or if the person named does not survive an Eligible Individual, the Beneficiary will be the surviving person or persons in the first of the following classes in which a member survives:

A. Spouse.
B. Children, including legally adopted children.
C. Parents.
D. Brothers and sisters.
E. Executor or administrator.

Eligible Employees may change a Beneficiary by providing the Administrative Office such written notice as the Trustees may require.

Section 19. Birth (or Birthing) Center – A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
    - It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post partum care, and care of a child born at the center.
    - It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
    - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
    - It provides at least two beds or two birthing rooms.

- It is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
- It has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It has the capacity to administer local anesthetic and to perform minor Surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

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.

Section 20. Board or Board of Trustees – The term "Board" or "Board of Trustees" means the Board of Trustees established by the Trust Agreement.

Section 21. Calendar Month – The term "Calendar Month" means any one of the twelve months of the year beginning with the first day of that month.

Section 22. Calendar Year – The term "Calendar Year" means January 1 through December 31 of each year.

Section 23. Coinsurance – that portion of Eligible Health Care Expenses for which the covered person has financial responsibility to pay. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses after a deductible has been met.

Section 24. Continuing Care Patient means an individual who, with respect to a provider or facility:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

In the context of Continuing Care Patients, **Termination** includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Section 25. Corrective Appliances – The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic).

Section 26. 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 (not including breast reconstruction subject to WHCRA), or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Section 27. Cost-sharing – A term to mean the amount of money a plan participant or beneficiary is responsible for paying for a covered item or services under the terms of the plan, 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. Cost-sharing does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the plan. The **cost-sharing amount** for emergency and non-emergency services at Network Facilities performed by Out-of-Network Providers will be based on the recognized amount.

Section 28. Covered Medical Expenses – See the Articles on Medical Benefits.

Section 29. Custodial Care – Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are 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.

Section 30. Deductible – The amount of Eligible Medical or Dental Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the Schedule of Medical Benefits and Schedule of Dental Benefits in this document.

Section 31. Dependent – The term "Dependent" means:

a. the Eligible Employee's lawfully married Spouse; and

b. the Eligible Employee's eligible children (whether married or unmarried) to the last day of the month in which they reach their 26th birthday, including:

   1) **Son or daughter** (proof of relationship and age shall be required).

   2) **Stepson or stepdaughter** (proof of relationship and age shall be required).

   3) **Legally adopted child or child placed for adoption** with the employee (proof of adoption or placement for adoption and age may be required). The term "legally adopted children" shall include children placed for adoption and as to which the Eligible Employee assumes and retains a legal obligation for total or partial support in anticipation of adoption of said children. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

   4) A child named as an "alternate recipient" under a **Qualified Medical Child Support Order (QMCSO)**.

c. **Disabled Dependent Child Age 26 and Older:** Benefits can be continued for never married children (age 26 and older) who are incapable of earning a living because of mental or physical disability with a disability that existed prior to the attainment of the Plan's age limit, and who are chiefly dependent on the Eligible Employee for support on the date they cease to be eligible for benefits due to attainment of the limiting age. Notice and proof of such disability must be submitted in writing to the Trustees within 31 days of the date the Dependent Child's eligibility would otherwise terminate. Coverage for such children can be continued for the duration of the incapacity provided coverage does not terminate for any other reason. The Plan may require periodic proof of disability and you will have 31 days from the date of the request to provide this proof before the child is determined to be ineligible.

No person will be eligible both as an Eligible Employee and as a Dependent or as a Dependent of more than one Eligible Employee.

No claims can be considered for payment under the Plan in the absence of specific documentation to substantiate dependent status, including accurate Identification Information (e.g. Social Security Number, Medicare health insurance claim number, etc.).

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 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.

With the exception of a Dependent Child who is permanently and totally disabled prior to age 26 years, coverage will terminate on the last day of the month in which the child reaches their 26th birthday. See also the termination provisions for Dependent Children listed in the Eligibility Article of this document.

The following individuals are not eligible under the Plan: a foster child, a child under a legal guardianship order, a spouse of a Dependent Child (e.g. employee's son-in-law or daughter-in-law), Domestic Partner, child of a Domestic Partner or a child of a Dependent Child (e.g. employee's grandchild).

Section 32. Doctor or Physician – The term "Doctor" or "Physician" means a person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to prescribe and administer drugs, under the state or jurisdiction where the services are rendered who acts within the scope of his or her license. See also the definition of Health Care Practitioner.

Section 33. Durable Medical Equipment (DME) – Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Non-durable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Section 34. 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's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Section 35. Eligible Employee – The term "Eligible Employee" means each Active Employee, Non-Jobsite Employee, and Self-Pay Employee.

Section 36. Eligible Individual or Eligible Person – The terms "Eligible Individual" or "Eligible Person" mean each Eligible Employee and each of his eligible Dependents, if any.

Section 37. Emergency Medical Condition – The term "Emergency Medical Condition" means a medical condition, including a mental health condition or substance use disorder, 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 or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Section 38. Emergency Services – means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the emergency department of a hospital** or of an independent freestanding emergency department, as applicable, 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).

Section 39. 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.

Section 40. Employee – The term "Employee" means an employee of a Participating Employer or the Union.

Section 41. 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.

Section 42. Experimental and/or Investigational 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 or Unproven. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

A service or supply will be deemed to be Experimental and/or Investigational or Unproven 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 Utilization Management program, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. 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;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. 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 unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the US 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.
5. Under the 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.** For individuals who will participate in a clinical trial, <u>precertification is required</u> 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. The routine costs that are covered by this Plan are discussed below:
    a. "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered 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.
    b. 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.

c. 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.

d. The plan may require that an eligible 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.

e. 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 section on How to File Claims and Claim Appeals 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. See the Utilization Management Program section for precertification information.

In determining if a service or supply is or should be classified as Experimental and/or Investigational or Unproven, 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 Utilization Management program:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. 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";
5. 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 the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the US such as Aetna, CIGNA or United Healthcare, or MCG, formerly Milliman Care Guidelines or, the American Dental Association (ADA), with respect to dental services or supplies.
6. 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.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

To determine how to obtain a Precertification of any procedure that might be deemed to be Experimental and/or Investigational or Unproven, follow the precertification requirements of the Plan explained in the Utilization Management Program section of this document.

Section 43. Food and Drug Administration (FDA) – The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Section 44. Fund or Trust Fund – The term "Fund" or "Trust Fund" means the National Roofers Union and Employers Joint Health and Welfare Fund.

Section 45. Generic (drug) – A generic drug is a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use. Generic drugs work in the same way and in the same amount of time as brand-name drugs. Generic drugs typically provide substantial dollar savings as compared to brand name drugs.

Section 46. Gene Therapy – Gene Therapy is a technique that uses human genes to treat or prevent disease in humans. Gene therapy involves introducing human DNA into an individual to treat a genetic disease. The new DNA usually contains a functioning gene to correct the effects of a disease-causing mutation. The technique can allow doctors to treat a disorder by inserting a gene into an individual's cells instead of using drugs or surgery. There are several approaches to gene therapy, including:

a) Replacing a mutated "faulty" gene that causes disease with a healthy copy of the gene.

b) Inactivating, or "knocking out," a mutated "faulty" gene that is not functioning properly.

c) Introducing a new gene into the body to help fight a disease or cure the disease.

Most often, human gene therapy works by introducing a healthy copy of a defective gene into the patient's cells. There have been rapid advancements in techniques that make it easier than ever to edit the human genome. Genome editing techniques, such as CRISPR/Cas9, allow editing of the genome, by removing, replacing, or adding to parts of the DNA sequence.

Although human gene therapy is a promising treatment option for conditions such as inherited disorders, some types of cancer, and certain viral infections, the technique remains risky and is often implemented for diseases that have no other treatment options or cures.

Section 47. Genetic Counseling - Counseling services provided before 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. See also the Medical Benefits and Medical Exclusions Articles in this document for more information.

Section 48. 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. See also the Medical Benefits and Medical Exclusions Articles in this document for more information.

Section 49. 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. See also the Medical Benefits and Medical Exclusions Articles in this document for more information.

Section 50. 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 or talking at the expected age.

Section 51. Health Care Facility/Facility – a facility for the delivery of health care services including a Hospital, Ambulatory Surgical Facility/Center, Behavioral Health Treatment Facility, Birthing Center, Inpatient Hospice Facility, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Subacute Care Facility/Long Term Acute Care facility, Residential Treatment Facility, Urgent Care Facility, all of whom are legally licensed and/or legally authorized to provide certain health care services in that facility under the laws of the state or jurisdiction where

the services are rendered. Many of these facility terms are separately defined in this Article. For non-emergency services, **Health Care Facility** is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Section 52. Health Care Practitioner – The term "Health Care Practitioner" means a Physician (Doctor), Behavioral Health Practitioner, Chiropractor, Dentist, Nurse, Nurse Practitioner, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, Optometrist, Optician for vision plan benefits, Certified Surgical Assistant, Breastfeeding/Lactation Educator all of whom are 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 act within the scope of his or her license and/or scope of practice. To the extent required by Health Reform 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.

Section 53. Health Care Provider – The term "Health Care Provider" means a Physician, Health Care Practitioner or Health Care Facility (Hospital, Ambulatory Surgical Facility/Center, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, or Skilled Nursing Facility).

Section 54. Health Reform/Health Care Reform - the common term used to describe the law called Patient Protection and Accountable Care Act of 2010, as amended.

Section 55. Home Health Care – The term "Home Health Care" means intermittent Skilled Nursing Services provided b56y a licensed Home Health Care Agency.

Section 56. Home Health Care Agency – The term "Home Health Care Agency" means a licensed home health care agency that meets all of the following requirements:

A. It must primarily provide Skilled Nursing services and other therapeutic services under the supervision of Physicians or registered nurses.
B. It must be run according to rules established by a group of professional medical people, including Physicians and nurses.
C. It must maintain clinical records on all patients.
D. It must be licensed by the jurisdiction where it is located, if licensure is required, and run according to the laws of that jurisdiction which pertain to agencies providing home health care.
E. It must be certified by Medicare.

Section 57. Hospice - The term "Hospice" means a facility or organization licensed and operating according to law and certified by Medicare 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 six months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home or in a home-like inpatient hospice setting. The emphasis shifts from curing to keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

Section 58. Hospital - means a class of health care institutions that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which:

1. 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; and
2. provides diagnosis and treatment on an inpatient basis for compensation; and
3. is approved by Medicare as a Hospital.

The facility may also be accredited as a hospital by The Joint Commission (TJC). 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/Outpatient Surgery Facility/Center, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Inpatient Rehabilitation facility, Subacute Care Facility/Long Term Acute Care facility or other residential treatment facility or place for rest, Custodial Care, or facility for the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

Section 59. Illness/Sickness – The term "Illness" or "Sickness" shall mean bodily sickness or disease and psychiatric disorders. It shall include congenital abnormalities of a newborn child. Illness must be diagnosed and treated by a Physician. For purposes of determining benefits payable, Illness includes pregnancy of an Active Employee and the spouse of an Active Employee and prenatal/postnatal office visits and Health Reform mandated preventive services for a pregnant dependent child. Illness does not include prenatal ultrasounds and delivery expenses for Dependent children.

Section 60. 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.

Section 61. Injury – The term "Injury" shall mean a condition which results independently of Illness and all other causes, and is a result of an externally violent force. Injury must be diagnosed and treated by a Physician.

Section 62. 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 as noted in Article V-A.

Section 63. 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.

Section 64. Medically Necessary.

A. A medical or dental service or supply will be determined to be "Medically Necessary" by the Board of Trustees or its designee if it:
   1. Is provided by or under the direction of a Physician who is authorized to provide or prescribe it; and
   2. Is determined by the Board of Trustees or its designee to be necessary in terms of generally accepted medical standards in the community in which it is provided; and
   3. It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and it is not provided solely for the convenience of the patient, Physician or Hospital; and it is an "Appropriate" service or supply given the patient's circumstances and condition; and it is a "Cost-Effective" supply or level of service that can be safely provided to the patient; and it is safe and effective for the Illness or Injury for which it is used.

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-Effective" 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 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 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's office or other less costly facility will **not** be considered to be Medically Necessary if it is furnished in a Hospital or other more costly facility.

G. The non-availability of Physicians or alternatives to provide medical services will **not** result in a determination that continued confinement in a Hospital 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 Physician 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, or any Hospital.

Section 65. Medicare – The term "Medicare" as used herein means the program established by the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

Section 66. 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. 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.

Section 67. Non-Durable 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, plastic tubing, hypodermic syringes, or cleansing solutions, etc. Only those non-durable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Section 68. Non-Jobsite Employee – The term "Non-Jobsite Employee" means those employees of a Participating Employer or Union who are not covered under a collective bargaining agreement and who are eligible to participate in this Fund subject to the execution of a Non-Jobsite Participation Agreement. Self-employed persons are not eligible to participate in this Fund. Therefore, contributions cannot be accepted from self-employed persons, owners, or partners and they may not be included as Non-Jobsite Employees for benefits provided by this Fund.

Section 69. Non-Occupational Injury or Illness – The term "Non-Occupational Injury or Illness" means any Injury not arising out of or in the course of any employment for wage or profit or any Illness not entitling the person who has contracted the Illness to benefits under any worker's compensation or occupational disease law.

Section 70. No Surprises Act and No Surprises Act Services – means the federal No Surprises Act (Public Law 116-260, Division BB) and services subject to it, such as emergency services, non-emergency services from an Out-of-Network provider at an In-Network Health Care Facility, and air ambulance services.

Section 71. 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 to be an office visit: a telephone discussion with a Physician or other Health Care Practitioner, internet/virtual office visit, 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.

Section 72. 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.

Section 73. Out-of-Network Emergency Facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to emergency services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health

insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

Section 74. Out-of-Network Provider means health care provider who does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Section 75. Out-of-Pocket Limit - the Out-of-Pocket Limit is the most you pay during a one year period (the plan year) before your medical plan starts to pay 100% for covered essential health benefits. See Article V-A for more details.

Section 76. Participating Employer – The term "Participating Employer" means any employer signatory to or otherwise bound by a collective bargaining agreement with the Union, which requires contributions of behalf of that employer's employees to this Trust Fund.

Section 77. Physical Therapy - 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.

Section 78. Physician: see Doctor.

Section 79. Plan – The term "Plan" means these Benefit Rules as adopted and thereafter amended by the Board of Trustees.

Section 80. Plan Year – The term "Plan Year" means the 12 consecutive month period from June 1 through May 31 of the next Calendar Year.

Section 81. PPACA - refers to the Patient Protection and Affordable Care Act of 2010, as amended. Also referred to as the Health Reform law.

Section 82. Preferred Provider Organization (PPO or In-Network) – The term "Preferred Provider Organization" ("PPO" or "In-Network") refers to 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.

Section 83. 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, and preventive care and screenings for women and children as recommended by the Health Resources and Services Administration (HRSA).

Section 84. 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.

Section 85. Provider - See the definition of Health Care Provider.

Section 86. 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.

Section 87. Qualifying Payment Amount (QPA) – means generally the median contracted rates of the plan or issuer for the item or service in the geographic region.

Section 88. Recognized Amount – For items or services furnished by an Out-of-Network provider or an Out-of-Network emergency facility, **Recognized Amount** means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For air ambulance services, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Section 89. 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.

Section 90. Rehabilitation Therapy Services - Physical, occupational, or speech therapy (and cardiac rehabilitation and pulmonary rehabilitation) that is prescribed by a Physician 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. See the Schedule of Medical Benefits and the Medical Exclusions Article of this document to determine the extent to which Rehabilitation Therapies are covered. See also the Medical Exclusions Article on Rehabilitation Therapy Services Exclusions (Inpatient or Outpatient).

1. **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.
2. **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 services are not covered by the Plan.**
3. **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.**

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 helping individual attain certain functions that they never have acquired.

Section 91. 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 the Plan.

Section 92. 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 people 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.

Section 93. Self-Pay Employee – The term "Self-Pay Employee" means any person who meets the eligibility requirements for Self-Payment hereunder as established by the Board and as amended from time to time.

Section 94. Serious and Complex Condition – means with respect to a participant, beneficiary, or enrollee under the Plan one of the following:

1. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;

2. in the case of a chronic illness or condition, a condition that is—

    a. is life-threatening, degenerative, potentially disabling, or congenital; and

    b. requires specialized medical care over a prolonged period of time.

Section 95. Skilled Nursing Facility (SNF) (also called a Convalescent Care Facility or Extended Care Facility) – The term "Skilled Nursing Facility" means an institution which:

A. Provides skilled nursing care with 24 hours a day supervision of a Doctor or Registered Nurse.

B. Has available at all times the services of a Doctor who is a staff member of a Hospital.

C. Provides 24 hours a day nursing service by a Registered Nurse, Licensed Vocational Nurse or skilled Practical Nurse and has a Registered Nurse on duty at least 8 hours per day.

D. Maintains a daily medical record for each patient.

E. Is not a place for rest, for custodial care for the aged, for drug addicts or alcoholics, nor is a hotel or similar institution.

Section 96. Skilled Nursing Services (as provided through Home Health Care) **–** The term "Skilled Nursing Services" means services performed by a licensed health care professional which meet the following:

A. Ordered and provided under the direction of a Physician.

B. Skilled services are intermittent and part-time (nursing service duration not to exceed 16 hours/day typically on less than a daily basis).

C. Require the skills of technical or professional personnel (e.g. R.N., L.P.N., L.V.N.) in that the service is so inherently complex that it can be safely and effectively performed only by or under the supervision of this technical/professional individual.

D. Home health aide services are payable if provided for the direct care of the patient and the services are intermittent and part-time (duration not to exceed 16 hours/day typically on less than a daily basis).

Examples of skilled services include, but are not limited to: initiation of intravenous therapy and initial management of medical gases (e.g. oxygen).

Section 97. 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).

Section 98. 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, must 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.

Section 99. Speech Therapist - A person legally licensed as a professional speech therapist who acts within the scope of their license, 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.

Section 100. Subacute Care Facility - A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility or as a stand-alone facility, licensed and operated according to law and authorized to provide Subacute Care (sometimes called Specialty Care or post acute care or long term acute 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:

1. It is accredited by The Joint Commission (TJC) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or for treatment of tuberculosis; and
6. It is not a hotel or motel.

Subacute care facility is sometimes referred to as a specialty hospital or long term acute care (LTAC) facility.

Section 101. Substance Abuse (also called Substance Use Disorder) **-** A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless or 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 definition of Behavioral Health Disorder.

Section 102. Surgery - means 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 Trustees or their 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:

1) Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of Allowed Charge
Secondary and additional procedures	50% of Allowed Charge per procedure

2) Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of Allowed Charge
First site secondary and additional procedures	50% of Allowed Charge per procedure
Second site primary and additional procedures	50% of Allowed Charge per procedure

Section 103. 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), myofascial 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.

Section 104. Totally Disabled – The term "Totally Disabled" means with respect to an Active Employee that he is prevented, solely because of a **non-occupational** Illness or **non-occupational** Injury, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit, and with respect to a Dependent, that he or she is prevented solely because of a **non-occupational** Illness or **non-occupational** Injury, from engaging in all of the normal activities of a person of like age in good health. For purposes of Article II, Section 2 on "Continuation of Eligibility While Totally Disabled – Jobsite Employees" only, an Active Employee will also be deemed "Totally Disabled" as a result of an occupational Injury or Illness if he or she otherwise meets this definition.

Section 105. Transplant or Transplantation – The term "Transplant" or "Transplantation" means the transfer of organs (such as a kidney), or living tissues or cells (cornea, bone marrow, stem cells) from a donor to a recipient or from one body part to another with the intent to maintain the functional integrity of the transplanted 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 always allogenic.
- **Xenographic** refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xenographic transplants are **not** covered by this Plan.

Section 106. Trust Agreement – The term "Trust Agreement" means the Trust Agreement establishing the National Roofers Union and Employers Joint Health and Welfare Fund and any modification, amendment, extension or renewal thereof.

Section 107. Union – The term "Union" means the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO, or a participating Local Union thereof.

Section 108. 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.

Section 109. 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, 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.

Section 110. Utilization Management (UM) - 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. Utilization Management services (sometimes referred to as UM services, UM program, Utilization Review services, UR services, Utilization Management and Review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan.

Section 111. Utilization Management (UM) Company - The 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.

ARTICLE II: ELIGIBILITY FOR BENEFITS

Section 1. Establishment and Maintenance of Eligibility – Jobsite Employees.

A. **Initial Eligibility**

All Active Employees and their enrolled eligible Dependents (as described in Section 1-C below) shall be eligible for Fund benefits on the first day of the second Calendar Month which follows a period of not more than three consecutive Calendar Months during which when the Active Employee has worked at least **330 hours** (or such other number of hours as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document) for one or more Participating Employers, and the Fund has received contributions from the Participating Employers.

1. Temporary eligibility change: regarding Initial Eligibility, effective for participants dispatched for work between May 1, 2024 through December 31, 2025 only: new Active Employees will have 330 hours (or such other number of hours as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document) advanced to their hour bank (an "hour bank loan") in their first month of work. Coverage will then begin the first of the month following the month that employment began. Each month, any hours worked will apply first toward the minimum 110 hours (or such other number of hours as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document) required to maintain eligibility. Any excess will be applied to repay the member's hour bank loan.

A. In order to qualify, an Active Employee must:

i. be dispatched to work in the jurisdiction of the Plan,

ii. by a participating local to a Contributing Employer between May 1, 2024 and December 31, 2025,

iii. not have any Covered Hours under or participated in the Plan in the 24 months prior to dispatch and beginning employment,

iv. have had employer sponsored medical coverage in the month of or prior to dispatch by the participating local.

B. Exceptions and Limitations:

i. If the hour bank loan is not fully repaid after 12 months of the Active Employee's month of initial eligibility, then the obligation to repay the hour bank loan will end and any remaining hour bank loan hours will be cancelled. At that point, the member must satisfy the continuing eligibility requirements under the Plan in order to continue coverage.

ii. If during the first 12 months of coverage a member loses Plan coverage and has an outstanding hour bank loan, the loan and banked hours will be cancelled. In order to have coverage reinstated, the member must reestablish Initial Eligibility by working at least 330 hours (or such other number of hours as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document) in a period of not more than three consecutive Calendar Months.

iii. All other provisions of the Plan, including those on establishing and continuing eligibility, continue to apply. The Board of Trustees reserves the right to extend or terminate this eligibility provision under the Plan at any time, and may take action to terminate, replace or amend any part of the Plan.

B. Continuation of Eligibility

Eligibility shall continue for an Active Employee if his Hour Bank (as defined below) contains at least **110 hours** (or such other number of hours as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document) of work credit. An **Hour Bank** is an account of hours established for each Active Employee and includes all hours credited thereto less all hours deducted therefrom, as provided below:

1. Subject to the maximum set forth in Subsection 3 below, and the hour bank loan set forth in Subsection 1 above, all hours properly reported by an Employee for one or more Participating Employers shall be credited to the Active Employee's Hour Bank.
2. **110 hours** (or such other number of hours as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document) of work credit shall be deducted from an Active Employee's Hour Bank to maintain eligibility for one month.
3. The maximum balance in an Active Employee's Hour Bank shall be **330 hours** (or such other number of hours as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document) after the deduction has been made for the current month's eligibility.
4. In order that there will be sufficient time for Employer reports to be received and processed by the Administrative Office, a "**lag month**" will be used in determining monthly eligibility. The lag month is the month between the payroll period and the month of actual coverage.
5. All hours of work credit will be deducted from an Active Employee's Hour Bank if, following the Employee's leaving the employ of Participating Employers, the Employee takes industry employment for an employer that is not a Participating Employer.
6. Subject to the discretion of the Trustees, the hours of work credit in an Active Employee's Hour Bank may be held in suspense for a Jobsite Employee who moves to employment providing Non-Jobsite Employee eligibility under Section 4 of this Article II. Upon the return of such an individual to Jobsite Employment, such hours may be reinstated into the individual's Hour Bank.

C. **Dependent Eligibility**.

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, 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 month following their proper enrollment.

Enrollment Process.

All Dependents are considered properly enrolled upon the employees' completion of an enrollment form and the submission of the information required under the Proof of Dependent Status Provisions below.

- **Special Rule for Newly-Acquired Spouse or Stepchild** - - A newly acquired Spouse or stepchild 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 date of marriage. You will be requested to complete an enrollment form and provide proof and identification data for the Dependent Spouse or stepchild (if requested). If a newly acquired Spouse or stepchild is not properly enrolled within this 90 day period, then eligibility for that Dependent will begin on the first day of the month following their proper enrollment.
- **Special Rule for Newborns** - - Newborn Dependent Children of an Eligible Employee will be covered from the date of birth, if properly enrolled within 90 days of their birth. You 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 begin on the first day of the month following their proper enrollment.

- **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" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. You 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 month following their proper enrollment.

  If a child is Placed for Adoption with you and is properly enrolled, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

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 (SSN) of the dependent(s) you wish to add to the Plan, and any of the following:

- **Marriage**: copy of the certified marriage certificate.
- **Birth**: copy of the certified birth certificate.
- **Adoption or placement for adoption**: court order paper signed by the judge.
- **Stepchild**: copy of the certified marriage certificate and copy of the certified birth certificate.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document or National Medical Support Notice.
- **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 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 the child is dependent chiefly on you and/or your Spouse for support and maintenance; and the disability existed before the child's attainment of the Plan's age limit. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.

Section 2. Continuation of Eligibility While Totally Disabled – Jobsite Employees.

If an Active Employee becomes Totally Disabled and the disability lasts for more than 30 days, no deduction will be made from his Hour Bank during the time beginning on the first day of the month in which the disability begins. In other words, the Hour Bank accumulation will be "frozen" and all Fund benefits will continue. This extended coverage may continue until the first day of the month in which the disability ends or the first day of the fourth month of disability (or such other period of disability as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document), whichever occurs sooner. However, in order to be eligible for this continuation, the Active Employee must have a Physician's statement certifying the disability and must advise the Administrative Office of the disability within three months of the date of the Illness or Injury causing the disability.

Section 3. Reinstatement of Eligibility – Jobsite Employees.

If an Active Employee's eligibility terminates because of insufficient hours in the Hour Bank, it can be reinstated if his/her Hour Bank shows a total of **at least 110 hours** (or such other number of hours as may be specified for the participation of a group of Employees in the Plan Eligibility Chart located toward the front of this document) within the 3 Calendar Month period subsequent to the termination of eligibility. Such reinstatement shall be effective on the first day of the second Calendar Month following the Calendar Month in which this requirement is met. If an Active Employee's eligibility is not reinstated after the specific period consecutive Calendar Months, any hours remaining in the Hour Bank shall be canceled, and such Active Employee shall again become eligible only by satisfying the eligibility requirements of a new Employee as set forth in Section 1 of this Article II.

Section 4. Establishment and Maintenance of Eligibility – Non-Jobsite Employees.

The Trustees may approve the participation of Non-Jobsite Employees by entering into a Participation Agreement with a Participating Employer, which Agreement shall specify the terms and conditions of such participation. The date of initial eligibility for Non-Jobsite Employees of a new Participating Employer shall be the first day of the second month following the date the Employer signed the Participation Agreement, provided the Non-Jobsite Employees have worked and the Employer has paid contributions as specified in the Participation Agreement.

Subsequently hired Non-Jobsite Employees will become eligible on the first day of the second month they are reported to the Trust by the Employer in accordance with the Participation Agreement.

Non-Jobsite Employee eligibility will continue so long as the Employee is employed in accordance with the Participation Agreement and properly reported to the Fund by the Participating Employer and the contributions have been received.

Section 5. Family Medical Leave Act.

In accordance with the Family and Medical Leave Act of 1993 (FMLA), qualified Employees are entitled to unpaid leave and can continue to maintain coverage under this Plan for the duration of the leave. Contributions will be maintained on the same terms as prior to the leave. Qualifications for this provision are outlined in the Family and Medical Leave Act of 1993 and subsequent regulations. To find out more about your entitlement to family or medical leave as required by federal and/or state law, and the terms on which you may be entitled to it, contact your employer.

Section 6. 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. Once the Administrative Office receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for up to 24 months, 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 and when applicable will automatically be provided with a COBRA election notice.

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.

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.

Contact the Administrative Office to obtain USERRA benefit election information at no charge. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Section 7. Termination of Eligibility.

A. An Active Employee's (or Non-Jobsite Employee's) eligibility will terminate on the last day of the Calendar Month for which the individual does not qualify under the foregoing sections of this Article II. Notwithstanding the foregoing, if an Active Employee enters the uniformed military service of the United States, his/her Hour Bank can be held until such Active Employee is released from military service and returns to employment with a Participating Employer within ninety days following his/her release, if requested by the Active Employee and approved by the Board of Trustees. If an Hour Bank is held under this provision,

the Active Employee's eligibility will terminate on the last day of the Calendar Month in which he enters the uniformed military service.

B. The eligibility of a Dependent of an Active Employee will terminate on the earlier of the following dates:

1. The last day of the Calendar Month in which the Active Employee's eligibility terminates.
2. In the event of the death of the Active Employee, coverage shall terminate for his/her eligible Dependents on the last day of the Calendar Month in which the deceased Active Employee's Hour Bank falls below the number of hours specified for the participation of that Employee's group necessary to maintain eligibility. For continuation of benefits, see Section 9.
3. For the Spouse, the date of entrance into full-time active military duty.
4. The last day of the Calendar Month in which he/she no longer qualifies as a Dependent, as defined in Article I.

Section 8. Rescission of Coverage.

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when contributions 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 that is prohibited by the terms of the Plan.

Section 9. COBRA Continuation Coverage Self-Payment Provision for Active Employees and Their Dependents.

A.

1. **Employee Self-Payment.**

   If a former Active Employee or Non-Jobsite Employee loses eligibility for Fund benefits due to termination of employment or reduction in work hours or service in the Uniformed Service of the United States, the individual and/or his/her eligible Dependents may temporarily continue eligibility by making self-payments directly to the Administrative Office.

   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**. 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. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. 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 plan within 30 days, even if that plan generally does not accept late enrollees.

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

2. **Notice.**

   The Administrative Office of the Fund will determine if an Employee has suffered a termination of employment or reduction of hours from the employment activity reports of the Participating Employers. The Administrative Office of the Fund will notify a former Employee who has lost eligibility.

   The affected former Employee will have until the **later of 60 days** from the date of such notice, or 60 days from the date eligibility is lost to notify the Administrative Office of his/her election to temporarily continue eligibility by making self-payments for COBRA continuation coverage.

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

3. **Self-Payment Amount – Benefits Available.**

The amount of the monthly self-payment(s) for former Employees will be established by the Board of Trustees and is subject to change in their discretion. The self-payment(s) charged will represent continuation of those Medical, Dental and Vision Benefits provided to the former Employees and their Dependents by the Fund.

In no event will an employee on military leave in the Uniformed Services of the United States have an obligation to make a self-payment for the first month of such leave.

4. **Maximum Number of Self-Payments.**

The rights of a former Employee and/or his eligible Dependents to continue coverage under this Subsection A shall be continued until the end of the month in which the **earliest** of the following events occurs:

a. The Trust Fund ceases providing any benefits to any participant;

b. Coverage ceases by reason of the failure of the Employee and/or his/her eligible Dependents to timely make the self-payments required by the Trustees;

c. The former Employee and/or his/her eligible Dependents become covered under any group health plan; d. The former Employee and/or his/her eligible Dependents become entitled to Medicare;

e. Eighteen (18) months have passed since the end of coverage under the former Active Employee's Hour Bank or the former Non-Jobsite Employee's eligibility. Notwithstanding the foregoing:

(1) No Dependent of an Employee which Employee becomes eligible for Medicare while eligible as an Employee hereunder shall be denied the right to continue self-payments to the fund under this provision until 36 months have passed from the date the Employee became eligible for Medicare.

(2) In the case of an Employee or Dependent who was totally and permanently disabled for social Security award purposes on the date of the employment termination of an Employee, or within 60 days after that, up to **11 additional months** of self-payments may be allowed to bridge the gap between this provision and Medicare entitlement. In order to enjoy this additional extension of self-pay rights, the totally disabled individual is required to notify the Administrative Office of the Fund within 60 days of the date of Social Security's determination that he/she was disabled at the time of the Employee's termination of employment. Such individual is also required to notify the Administrative Office within 30 days of any final Social Security determination that he/she is no longer disabled. The additional disability extension of self-payment rights under this Subsection (e) (2) will terminate at the end of the month following the month in which a final Social Security determination is made that the individual is no longer disabled.

(3) In the case of an Employee who enters the Uniformed Services of the United States, 24 months is substituted for 18 months if the Employee elects USERRA instead of COBRA.

5. **Termination of Self-Payments.**

Once an Employee fails to make the required self-payment in full and within the specified time or has made the maximum number of self-payments specified in Subsection A (4) of this Section, he/she will no longer be permitted to make the self-payments described and must re-qualify for coverage under this Plan in accordance with Sections 1 through 4 of this Article.

B.

1. **Dependent Self-Payments.**

If any Employee's Dependent or Dependents lose coverage for the benefits of the Plan because of:

a. The divorce of an Employee,

b. The death of an Employee,

c. The attainment of Medicare eligibility by a Self-Pay Employee, or

d. In the case of a Dependent child, the failure of such Dependent to meet the definition of a Dependent under the Plan,

they may continue eligibility by making self-payments directly to the Administrative Office.

2. **Notice.**

Dependents whose coverage under this Plan is affected by the events described above are responsible for notifying the Administrative Office of those facts within 60 days of the affecting event. The Administrative Office will then notify the Dependent(s) of their rights under these provisions within 14 days.

The Dependent(s) will have until the **later of** 60 days from the date of the notice from the Administrative Office, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making self-payments.

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.

3. **Self-Payment Amounts – Coverage Available.**

The amount of the monthly self-payment(s) for Dependent(s) affected the events described above will be established by the Board of Trustees and is subject to change in their discretion. The self-payment(s) charged represent continuation of those Medical, Dental and Vision Benefits being provided for Dependents by the Fund.

4. **Maximum Number of Self-Payments.**

The right of Dependent(s) to make self-payments shall be continued until the end of the month in which the **earliest** of the following events occurs:

a. The Trust Fund ceases providing any benefits to any participant;

b. Coverage ceases by reason of the failure of the Dependent(s) to timely make the self-payments (in full) required by the Trustees;

c. The Dependent(s) become covered under any other group health plan;

d. The Dependent(s) become entitled to Medicare;

e. Thirty-six (36) months have passed since the end of the regular coverage under the provisions of this Plan.

Once COBRA coverage terminates on account of the maximum number of self-payments, it cannot be reinstated. Questions about COBRA should be directed to the Administrative Office.

C. **Payment of Self-Payment Premium for Employees and Dependents.**

Initial self-payment(s) (retroactive to the date of loss of eligibility) must be paid no later than the 45th day after the date the Administrative Office is notified of the person's election to make self-payments.

Each subsequent self-payment is due on the first day of the month for which coverage is intended. **Self-payments received at the Administrative Office later than 30 days after the due date will not be accepted and rights to self-payment will terminate. There will be no waivers granted.**

IMPORTANT

- ✓ **There will be no invoices or reminders for COBRA premium payments.**
- ✓ **You are responsible for making sure that timely COBRA premium payments are made to the Administrative Office in full and on time.**
- ✓ **If you fail to make a periodic COBRA premium payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.**

For Monthly Payments, 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, the 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 as of the date for which the last full COBRA premium payment 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 month 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).

D. **Trustee Rights Concerning Self-Pay Eligible Individuals.**

The Board of Trustees reserves the right to request and receive from Self-Pay Employees and Dependents any pertinent information bearing on the eligibility of such persons for the benefits provided under the self-payment provisions of this Trust Fund. The failure of any such person to promptly respond to the Trustees' request for such information may lead to the self-payment rights described herein being suspended or terminated, in the discretion of the Trustees.

E. **Self-Pay Eligible Individuals Affected by Multiple Events.**

No person may enjoy any one continuous self-pay coverage extension under the Trust Fund and Plan beyond 36 months from the end of the month in which the **first** event giving rise to self-payment rights with respect to that person occurred.

Section 10. Special Enrollment.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You and/or your Dependents may also enroll in this Plan if you or your Dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your Dependents lose eligibility for that coverage or become eligible for a premium assistance program through Medicaid or CHIP. However,

you must request enrollment within 60 days after the Medicaid or CHIP coverage ends or is determined to be eligible for such assistance.

This Plan complies with the Federal law regarding Special Enrollment by virtue of the fact that all eligible employees and their eligible dependents are automatically enrolled in this Plan as soon as the eligibility requirements of the Plan are met. There is no option to decline coverage, except dental and vision coverage. For more information about Special Enrollment under this Plan contact the Administrative Office. See also Section 1 on Dependent special enrollment opportunities.

Section 11. Notice Procedures.

The following notices must be made, in writing, and within the specified timeframes, to the Administrative Office:

A. Notice of divorce, Medicare eligibility or failure to meet the Plan's definition of Dependent;

B. Notice of a Social Security disability award or the revocation of that award; or

C. Notice of any other event giving rise to self-payment rights under Section 9.

Such notices must include either the information that will allow the Administrative Office to determine the self-payment rights of those individuals involved or the contact information for the person from whom such information may be obtained.

ARTICLE III – DEATH AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Section 1. Death Benefits for Active Employees and Non-Jobsite Employees.

If an Active Employee or a Non-Jobsite Employee in a group eligible for this benefit dies from any cause, the Fund will pay, subject to the terms and conditions of the Plan, the amount applicable to Employees in that group of Employees. Benefit amounts are outlined on the Schedule of Life, AD&D and Disability Income Benefits.

Section 2. Death Benefits for Dependents of Active Employees and Non-Jobsite Employees.

If a Dependent of an Active Employee or a Non-Jobsite Employee in a group eligible for this benefit dies from any cause, the Fund will pay, subject to the terms and conditions of the Plan, the amount applicable to Dependents of Employees in that group of Employees. Benefit amounts are outlined on the Schedule of Life, AD&D and Disability Income Benefits, located toward the front of this document. Additionally, dependent children are eligible for death benefits to age 26, without a requirement to maintain student status.

Section 3. Accidental Death & Dismemberment Benefits for Active Employees & Non-Jobsite Employees.

A. **Benefits.**

When an Active Employee or a Non-Jobsite Employee in a group eligible for this benefit is accidentally injured while his/her coverage is in effect and the injury directly results in one of the following total losses which occurs (1) without other causes; and (2) within 90 days of the accident; the Fund will pay a benefit based on the Principal Sum applicable to Employees in that group of Employees.

Accidental Death and Dismemberment Benefits for Active Employees and Non-Jobsite Employees	
Type of Loss	**Benefit Pays**
Accidental Death	The Principal Sum
Both Hands or Both Feet	The Principal Sum
Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand or One Foot	One-half the Principal Sum
Sight of One Eye	One-half the Principal Sum

The maximum payable for all losses sustained in a single accident may not exceed the Principal Sum. With respect to hands and feet, total loss means severance at or above the wrist or ankle joints. With respect to eyes, total loss means complete and permanent loss of sight.

B. **Exclusions and Limitations.**

This benefit does not cover losses caused by:

1. War or any act of war, whether declared or not, or service in the armed forces of any country while such country is engaged in war, or police duty as a member of any military, naval, or air organization;
2. Suicide, the attempt thereof, or any intentional self-injury while sane or insane;
3. Or contributed to by diabetes;
4. Disease or infection, except pyogenic or septic infections of accidentally sustained visible wounds;
5. Injury to the Employee while committing a felony; or
6. Injection, inhalation, or ingestion of substance for purposes other than those prescribed by a Doctor.

Section 4. Payment.

All Employee Death Benefits will be paid to the Employee's Beneficiary. Dependent Death Benefits and Dismemberment Benefits will be paid to the Employee. Death and Accidental Death and Dismemberment Benefits may not be assigned. Benefits will be paid in a lump sum unless some other method of payment has been requested in writing and is approved by the Trustees.

ARTICLE IV – WEEKLY DISABILITY INCOME BENEFITS

Section 1. Benefits.

If an Eligible Employee (other than a self-pay Employee) becomes Totally Disabled as a result of a non-occupational bodily Injury or Sickness while covered hereunder, and as a result of the Injury or Sickness is prevented from performing his/her regular or customary occupation, the Fund will, subject to the provisions hereinafter set forth, pay to the Employee the amount per week applicable to the Employee's group. Benefit amounts are outlined on the Schedule of Life, AD&D and Disability Income Benefits located toward the front of this document.

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 taxes will be deducted from this amount and reported to the Internal Revenue Service on behalf of the Employee.

Section 2. Payment of Benefits.

Payments begin with the seventh day of disability (or the date of Hospital confinement, if earlier) due to Sickness; however, as to accidental Injuries, the benefit will 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.

Section 3. Period of Disability.

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

A. 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 Employee returns to work on a full-time basis for at least one day.

B. 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 Employee has returned to work on a full-time basis for at least two consecutive weeks.

Section 4. Limitations.

The foregoing benefit will only be provided for:

A. Those days on which an Employee is under the care of a legally qualified Physician. A period of disability will be considered to have started on the date an 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 Employee was first seen and treated personally by a Physician for the disability.

B. Those days on which an Employee is not performing work for compensation or profit.

C. Disabilities that commence while covered as an Employee for Fund benefits and then, if due to Injury, which Disabilities commence within 90 days of the Injury.

D. Disabilities resulting from an Injury or Sickness to which the Workers' Compensation Act or any similar law of any jurisdiction is not applicable. In this regard, the Fund does not provide benefits for any Injury from or in the course of any work for pay or profit.

E. Disabilities which do not result from:

   1. Any act of war, declared or not;
   2. Self-inflicted Injury to the Employee (unless the attempt arises as a result of a physical or mental health condition); or
   3. The Employee's alcohol and/or drug abuse, unless Medically Necessary.

ARTICLE V-A – MEDICAL BENEFITS

Section 1. Overview of Medical Benefits.

When an Eligible Person incurs Eligible Medical Expenses, as shown in the Schedule of Medical Benefits in the front of this document and as further explained in this Article, the Fund will pay benefits.

"Eligible Medical Expenses" are limited to those that are:

a. Determined by the Trustees or their designee to be **"Medically Necessary,"** but only to the extent that the charges for services other than those subject to the No Surprises Act are **"Allowed Charge"** (as those terms are defined in Article I); and

b. **Not services or supplies that are excluded** from coverage (as provided in the Medical Exclusions Article); and

c. **Services or supplies the charges for which are not in excess** of any applicable maximum plan benefit limit.

Generally, **the Plan will not pay all Eligible Medical Expenses.** Usually, Eligible Persons will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts incurred that are Eligible Medical Expenses. See also the section on Out-of-Pocket Limit described in this Article.

The Plan may provide for **precertification of care or other Utilization Management Services**. Information on such precertification services and how they must be obtained is explained in the Utilization Management Program section located toward the front of this document.

Section 2. PPO Network Heath Care Provider Services.

In an effort to control health care costs and reduce an Eligible Person's out-of-pocket expenses, the Fund may enter into agreements with Preferred Provider Organizations (PPOs). An Eligible Person may select any provider of his or her choice when medical care is needed. However, **if a Preferred Provider is selected, the Eligible Person's cost will be reduced considerably.** The PPO provider cannot charge more that the Plan allows in accordance with a contracted schedule of allowances for certain charges.

Out-of-Network Health Care Providers may bill the Plan Participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing (as defined in the Definitions Article), except that Out-of-Network Providers may not balance bill for No Surprises Act Services. Information on the Preferred Provider Organizations (PPO) is explained in the PPO section located toward the front of this document.

Section 3. Deductible.

Each calendar year, Eligible Persons (and **not** the Plan) are responsible for paying Eligible Medical Expenses until the individual has satisfied the annual Deductible. The Plan then begins to pay benefits.

a. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.

b. Deductibles under the Plan are accumulated on a Calendar Year basis.

c. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. Non-Eligible Medical Expenses and Copayments do not count toward the Deductibles.

d. There are two types of Deductibles: Individual and Family.

   1) The **Individual Deductible** is the maximum amount one Eligible Person has to pay toward Eligible Medical expenses before Plan benefits begin. The Plan's Individual Deductible is explained on the Schedule of Medical Benefits.

   2) The **Family Deductible** is the maximum amount that a family of three or more persons is responsible for paying toward Eligible Medical Expenses before Plan benefits begin. The Plan's Family Deductible is explained on the Schedule of Medical Benefits.

e. **Deductible Carryover:** In order that the Deductible will not be applied late in one Calendar Year and soon again in the following year, this Plan honors a Deductible Carryover provision. Any Covered Expenses

incurred during the last three months of a Calendar Year which apply toward the Deductible, whether or not it is fully satisfied, (e.g. charges incurred in October, November and December), may also be applied toward the Deductible for the following Calendar Year.

Section 4. Coinsurance.

a. Once an Eligible Person has met the annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and the individual (and **not** the Plan) is responsible for paying the rest. The part the Eligible Person pays is called the patient's share of the Coinsurance. The Schedule of Medical Benefits in this document details the Coinsurance applicable to the Medical Plan.

b. **Coinsurance Advantages when using a PPO Provider:** If an Eligible Person uses the services of a Health Care Provider who is a member of the Plan's PPO, the Eligible Person will be responsible for paying less money out-of-pocket. The Coinsurance percentage for a PPO Provider is higher than the Coinsurance percentage for a Non-PPO Provider. This feature is shown in the Schedule of Medical Benefits in this document.

c. **Accident Benefit:** The Plan pays 100% of eligible charges for the first $300 of Covered Expenses that are incurred within 90 days from an accident; thereafter normal plan cost-sharing (deductible, copay, coinsurance) applies. This benefit applies to a Doctor's treatment, medical supplies a Doctor prescribes, hospital confinement, x-rays, lab tests, care by a R.N. or therapist, ambulance, or oxygen. It does not apply to eye refractions, frames, lenses, contacts or their fittings or dental treatment (except for accidental injury to teeth/jaw).

Section 5. Copayment (Copay).

a. A Copayment (or copay, as it is sometimes called) is a set dollar amount the eligible Person (and **not** the Plan is responsible for paying when Eligible Medical Expense is incurred.

b. The Plan's Copayments are indicated in the Schedule of Medical Benefits in this document. The Plan has Copayments for retail and mail order outpatient prescription drugs.

c. Copayments may not be used to satisfy the Deductible.

d. Copayments do accumulate to the Out-of-Pocket Limit under the medical plan.

Section 6. Out-of-Pocket Limit (Annual Limit on In-Network Cost Sharing).

The Medical Plan has an **Out-of-Pocket Limit** which limits your annual cost-sharing for covered Essential Health Benefits received from in-network providers related to Medical Plan deductibles, coinsurance, and copayment to the amounts permitted under the Affordable Care Act and implementing regulations. The Out-of-Pocket Limit is the most you pay during a one-year period (the calendar year) before your health plan starts to pay 100% for covered Essential Health Benefits received from in-network providers. The Amount of the annual Out-of-Pocket Limit is explained on the Schedule of Medical Benefits.

a. 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.

b. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.

c. There is no Out-of-Pocket Limit on the use of Out-of-Network providers, except that emergency services, non-emergency services provided by an Out-of-Network provider at an In-Network Health Care Facility, and/or air ambulance services will accumulate to meet the in-network Out-of-Pocket Limit.

d. 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.

e. Medical Plan expenses and Outpatient retail and mail order drug expenses accumulate to meet separate Out-of-Pocket Limits as explained on the Schedule of Medical Benefits.

f. **The Out-of-Pocket Limit does not include or accumulate:**

1) Premiums and/or contributions for coverage,
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 Out-of-Network providers, except in the case of No Surprises Act Services,
4) Penalties for non-compliance with Utilization Management program requirements,
5) Charges in excess of the Medical Plan's maximum benefits,
6) Expenses for the use of Out-of-Network providers, except emergency services, non-emergency services provided by an Out-of-Network provider at an In-Network facility, and/or air ambulance services,
7) Expenses that are not considered to be Essential Health Benefits, such as TMJ syndrome treatment, and infertility treatment,
8) Dental Plan and Vision Plan expenses.

Section 7. Information About Medicare Part D Prescription Drug Plans For People 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 outlined in the Medical Plan in this document is "creditable." "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 15th through December 7th of each year).

For Medicare eligible individuals, 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 and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefit 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.

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 Plan's Medicare Part D Notice of Creditable Coverage (a copy is available from the Administrative Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

Section 8. Patient Protection Rights Of The Affordable Care Act.

The medical plan 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 Out-of-Network health care provider; however, payment by the Plan may be less for the use of a Out-of-Network provider and your costs may be more.

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 PPO network at their website listed on the Quick Reference Chart.

Section 9. 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. 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.

Section 10. Description of Covered Medical Plan Benefits.

A description of the Plan's Medical Benefits along with applicable Deductibles, Copayments and Coinsurance for use of an In-Network versus and Out-of-Network provider, appears in this document in a chart format called the "Schedule of Medical Benefits." Eligible Persons should use that Schedule of Medical Benefits along with this Article and the Articles addressing Medical Exclusions and Definitions to understand the benefits and limitations of coverage under the Medical Plan.

The following listing describes the Eligible Medical Expenses covered under the Plan (provided they are Medically Necessary for the care and treatment of an Eligible Person's Sickness or Injury). Benefits described are in alphabetical order.

Certain benefits must be precertified (pre-approved before services are provided). See the Utilization Management Program information in the front of this document.

A. **Ambulance**

1) **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.

2) **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.

3) Note that **non-emergency medical transportation services** are not payable under this Plan unless those travel expenses are related to a Plan-approved transplant as outlined under Transplantation in the Schedule of Medical Benefits in this document or are provided under an approved alternate care plan in conjunction with case management.

4) For ambulance services, the Plan pays 80% after the deductible is met.

B. **Ambulatory Surgical Care Facility/Center**

1) Ambulatory (Outpatient) Surgical Facility/Center is also called a surgicenter, or same day surgery.

2) Physician fees payable under Physician services. See also the definition of Surgery.

3) In-network facility fees payable at 80% after the deductible met; Out-of-Network facility fees payable at 50% after the deductible met.

4) **Certain services like spinal procedures, including all inpatient and outpatient spinal procedures if they are performed at a hospital or outpatient ambulatory surgical facility/center require precertification** by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.

C. **Behavioral Health Services** (includes Mental Health and/or Substance Abuse Treatment)

1) Office visits. In-network: $20 copay per visit, no deductible. All other services performed and billed during the office visits the Plan pays 80% after deductible met. Out-of-Network: 50% after deductible met.

2) Outpatient services including intensive outpatient treatment program. In-network: 80% after deductible met. Out-of-Network: 50% after deductible met.

3) Inpatient hospital admission. In-network: 80% after deductible met. Out-of-Network: 50% after deductible met.

4) Partial day treatment. In-network: 80% after deductible met. Out-of-Network: 50% after deductible met.

5) Residential Treatment Program (in-network only). In-network: 80% after deductible met. Out-of-Network: Not covered.

6) Behavioral health services do accumulate to the Plan's Out-of-Pocket Limit.

7) **Admission to an inpatient facility or residential treatment program must be precertified** to avoid a financial penalty. Contact the Utilization Management Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.

D. **Blood transfusion, blood products**, and supplies for administration. In-network: 80% after the deductible met; Out-of-Network: 50% after the deductible met.

E. **Chemotherapy.** In-network: 80% after the deductible met; Out-of-Network: 50% after the deductible met.

F. **Chiropractic Services.**

1) Maximum benefit is 12 visits per person per Calendar Year in- or out-of-network. See the Schedule of Medical Benefits for payment of these services.

2) In-network office visit charge: $20 copay per office visit, no Deductible. All other services performed and billed during an office visit the Plan pays 80% after Deductible met. Out-of-Network: 50% after the deductible met.

G. **Corrective Appliances.** In-network: 80% after the deductible met; Out-of-Network: 50% after the deductible met.

1) **Orthotic Devices** to support a weakened body part such as casts, splints, trusses (binder), braces and crutches;

a) Rental (but only up to the allowed purchase price of the device);

b) Purchase of standard models at the option of the Plan;

c) Repair, adjustment or servicing of the device or replacement of the device due to a change in the eligible person's physical condition or if the device cannot be satisfactorily repaired.

d) **Foot Orthotics** (orthopedic or corrective shoes and other supportive appliances for the feet) one pair is payable once every 4 years for adults and once in a period of 6 months for children under age 19 when replacement is required due to growth.

2) **Prosthetic Devices** to replace a missing body part such as artificial limbs and eyes, and prostheses following mastectomy, including their necessary replacements or repair.

H. **Diabetes Education.**

1) Coverage is payable, at no charge, when an in-network provider is used, for a formal diabetes education course/program taught by a Certified Diabetes Educator and recognized as an acceptable program by the American Diabetes Association. For Out-of-Network providers the Plan pays 50% after deductible met.

2) A diabetes education program is payable when a person is initially diagnosed with diabetes or pre-diabetes.

3) A refresher course is payable once each year for up to 5 times.

I. **Dialysis.**

1) **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.

2) In-network: 80% after the deductible met; Out-of-Network: 50% after the deductible met.

J. **Drugs: Outpatient Retail and Mail Order Prescriptions.**

1) 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.

2) Benefits for prescription drugs may be provided through the Plan's Prescription Drug Program. This prescription drug benefit utilizes a formulary. A **formulary** is a list of preferred outpatient prescription drug products, including strength and dosages, available for use by Plan participants. The formulary is also called a Performance Drug List (PDL). This Plan has adopted the prescription drug network's current formulary, including its preferred drug list, as the Plan's covered formulary. Based on the prescription drug network's formulary (which is updated from time to time), **certain drugs are not covered by the Plan**, and certain drugs are payable only when prior authorization is obtained through the Prescription Drug Program.

   Mandatory Generic Program. **This plan provides a mandatory generic program, meaning that if a brand name drug is dispensed in place of a generic, regardless if you or your doctor request it, you will pay the brand copay plus the difference in cost between the generic and brand name drug.**

3) Participants may obtain **diabetics care supplies** (e.g. insulin syringes, blood glucose meter test strips, lancets) from the retail pharmacy.

4) **Retail Drugs:** To obtain **up to a 30-day supply** of medication for the cost-sharing noted in the Drugs row of the Schedule of Medical Benefits, Eligible Persons must present their ID card to any in-network retail pharmacy.
   a) **Generic Drug:** The greater of a $5.00 copay or 25% of the cost of the drug.
   b) **Preferred Brand Drug:** The greater of a $20.00 copay or 25% of the cost of the drug.
   c) **Non-Preferred Brand Drug:** The greater of a $40.00 copay or 50% of the cost of the drug.
   d) **FDA-approved contraceptives for all females:** 100%, no cost-sharing for generic contraceptives for females when submitted with a prescription purchased at an In-network Retail or Mail Order location. No charge for brand prescription contraceptive drug only if a generic contraceptive is unavailable or medically inappropriate.
   e) CDC-recommended **vaccinations/immunizations** are payable at 100%, no cost sharing when obtained at an in-network retail pharmacy. Contact the Prescription Drug Program for more information.
   f) **Non Covered or Excluded Drugs:** You pay 100% of the prescription drug network discount amount (only if the Prescription Drug Network offers a discount on the drug).

5) **Mail Order (Home Delivery) Drug Service:** The medications can be mailed directly to the Eligible Person's home. The mail order service may be used 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. The Prescription Drug Program may supply further information. To use the mail order service, the Eligible Person should:
   - Have their Doctor write the prescription for a 90-day supply, with the appropriate refills.
   - Mail the prescription, copay and the mail order form to the Mail Order Services Department of the Prescription Drug Program. Forms may be obtained from the Prescription Drug Program.
   - Allow up to 14 days to receive the order.

   The Mail Order cost-sharing is noted below:
   a) **Generic Drug:** $10.00 copay.
   b) **Preferred Brand Drug:** $40.00 copay.
   c) **Non-Preferred Brand Drug:** $80.00 copay.

d) **FDA-approved contraceptives for females:** 100%, no cost-sharing for generic contraceptives submitted with a prescription purchased at an In-network Retail or Mail Order location. No charge for brand prescription contraceptive drug only if a generic contraceptive is unavailable or medically inappropriate.

e) **Non Covered or Excluded Drugs:** You pay 100% of the prescription drug network discount amount (only if the Prescription Drug Network offers a discount on the drug).

6) **Out-of-Network Retail Pharmacy:** If a prescription is filled in an out-of-network pharmacy location, the Eligible Person will need to pay for the drug at the time of purchase and later, send the drug receipt to the Prescription Drug Program. For eligible prescriptions, Eligible Persons will be reimbursed the billed charges minus the appropriate cost-sharing. Contraceptives are not reimbursed when obtained out-of-network.

7) **Prior Authorization:** Certain drugs require prior authorization (precertification) by the clinical staff of the Prescription Drug Program such as Specialty Drugs and compounded medication. Certain medication is excluded from coverage if prior authorization is not obtained by contacting the Prescription Drug Program.

8) **Quantity Limits:** The Prescription Drug Program should be contacted for information on which drugs have a **limit to the quantity payable** by the Plan.

9) **Step Therapy:** Contact the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document) for information on which drugs are part of the **step therapy program** where you first try a proven, cost-effective generic medication before moving to a more costly brand name drug treatment option, such as drugs to treat high cholesterol and stomach ulcers. The following chart shows the classes of drugs that are part of the step-therapy program:

Medical Condition	Brand-Name Drug	Generic Drug
High cholesterol	Lipitor 10 mg and 20mg Crestor 5 mg and 10 mg Lescol XL	simvastatin lovastatin pravstatin
Stomach ulcer or gastric reflux	Aciphex, Nexium, Prevacid	Omeprazole

10) Drugs that have not yet been approved by the FDA are not covered. New FDA-approved drugs will be covered by the Plan unless stated otherwise.

11) Copayments and Coinsurance for Retail and Mail Order Drugs are not applied to meet the Plan's Deductibles. The medical plan deductible does not apply to outpatient retail or mail order medication. Outpatient drug cost-sharing accumulates to a separate annual Out-of-Pocket Limit. The annual **Out-of-Pocket Limit on outpatient drugs** is the most you pay for covered generic, preferred brand, non-preferred brand and specialty drugs from in-network retail and mail order locations: **$1,600/person/calendar year $3,200/family/calendar year** (these amounts will be adjusted in accordance with law).

12) **Coverage of Certain Preventive Drugs under the Medical PPO Plan.** For any preventive care drug to be covered by the Plan, the drug must be:

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

Certain preventive care drugs are payable by this non-grandfathered medical plan, **at no charge when purchased at the Plan's network Retail pharmacy location or Mail Order Service**, in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Please contact Cigna at the number listed on the Quick Reference Chart for a complete list of covered preventive care drugs.

Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of preventive care drugs, this Plan will comply with the new requirements on the date required.

13) **Specialty drugs** are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are used by individuals with unique concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis, or hepatitis. These drugs **require prior authorization** and are managed because they often require special handling, are date sensitive and are usually available only in a 30-day quantity. For **Specialty Drugs** you pay:

a) **Generic:** 5% coinsurance to maximum of $75 per prescription for a 30-day supply

b) **Brand:** 5% coinsurance to a maximum of $150 per prescription for a 30-day supply

K. **Durable Medical Equipment (DME).**

Coverage is provided for equipment that meets the definition of Durable Medical Equipment, if its use is Medically Necessary and it is ordered by a Physician or Health care Practitioner, (in-network 80% after deductible met; Out-of-Network 50% after deductible met), as follows:

1) Rental (but only up to the allowed purchase price of the DME).
2) Purchase of standard models at the option of the Plan.
3) Repair, adjustment or servicing or Medically Necessary replacement of the Durable Medical Equipment due to a change in the Eligible person's physical condition or if the equipment cannot be satisfactorily repaired.
4) Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.
5) Insulin pumps and Blood glucose testing devices are considered payable durable medical equipment under this Plan. See the Drugs: Outpatient Retail and Mail Order Prescriptions (Section J in this Article) for information on supplies needed to operate these devices.
6) For the first 12 months following the birth of a child, coverage is provided for one standard manual or standard electric breast pump, plus breast pump supplies needed to operate the breast pump. Rental, purchase and repair is payable as outlined above. No charge when obtained in-network. Reimbursement for a breast pump and supplies from a Out-of-Network provider is payable at 50% after the deductible has been met.

L. **Emergency Services or Urgent Care Facility.**

1) Payable for **emergency services** provided for an emergency medical condition (as these terms are defined in this Plan).
2) **Urgent Care facility**. Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea or vomiting, or bladder infections.
3) Ancillary services (such as lab or x-ray) performed during the emergency facility or urgent care facility visit.
4) For Ambulance benefits, see Ambulance (listed alphabetically in this section).
5) If you receive emergency care at an Emergency Room and the physicians delivering the care are Out-of-Network providers, your eligible expenses will be processed at the in-network level of benefits and cost-sharing will accumulate to meet the in-network annual Out-of-Pocket Limit.
6) Copay waived if admitted to a hospital from the emergency room or urgent care facility.
7) There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. Also, the Plan will pay in-network cost-sharing for emergency services performed by a provider, in compliance with the No Surprises Act and its implementing regulations. See the definitions of Allowed Charge and No Surprises Act or contact the Administrative Office for more details.
8) **In-network and Out-of-Network Emergency Services** payable as follows: after the deductible is met and you pay a $250 copay per visit, the Plan pays 80% coinsurance.
9) **In-network Urgent Care Facility** payable as follows: after the deductible is met and you pay a $100 copay per visit, the Plan pays 80% coinsurance. Out-of-Network Urgent Care Facility payable as follows: after the deductible is met, the Plan pays 50% coinsurance.

M. **Family Planning.**

1) Surgical sterilization is covered. No charge for female sterilization performed in-network.

2) FDA-approved contraceptives for females are covered (at no cost from in-network providers) including oral birth control pills/patch, contraceptive injections such as Depo-Provera/Lunelle, intrauterine device (IUD), diaphragm, or an implantable birth control device are covered. Some contraceptives are payable under the Retail/Mail Order Prescription Drug benefit.

3) Contraceptive counseling and education for females (payable at no cost from in-network providers). Out-of-Network providers: 50% after deductible met.

4) For fertility diagnosis and treatment, after the deductible is met the first $10,000 per couple per lifetime is payable at the usual coinsurance in-network or out-of-network; thereafter, the Plan pays 10%. This benefit is not subject to the out-of-pocket limit. See also the Medical Exclusions Article.

N. **Gene Therapy**.

1) Medically necessary gene therapy is payable under this Plan. In-network 80% after deductible met; Out-of-Network 50% after deductible met.

2) **Gene Therapy services require precertification to avoid non-payment**, by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. The UM Company can also tell you the location of the In-Network Gene Therapy facilities.

O. **Genetic Testing and Counseling.**

1) Medically necessary genetic testing payable under this Plan (in-network 80% after deductible met; Out-of-Network 50% after deductible met) is for:
   a) state-mandated newborn screening tests for genetic disorders;
   b) 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;
   c) tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity;
   d) genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis;
   e) genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see the Preventive services row in the Schedule of Medical Benefits).
   f) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if all the following conditions are met:
      - the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and
      - the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and
      - the results of the test will directly impact clinical decision-making, outcome or treatment being delivered to the covered individual.

2) Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by this Plan.

3) No coverage for pre-parental genetic testing (also called carrier 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.

4) No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of individuals who are not covered under this Plan. Genetic testing costs may be covered for a non-covered individual only if such testing would directly impact the treatment of a covered plan participant.

5) Plan participants should use the Plan's precertification procedure or contact the Administrative Office to assist in determining if a proposed genetic test will be covered or excluded.

P. **Habilitative Services**

1) To help individuals attain certain functions that they never have acquired including treatment of delays in childhood speech and physical development, unless the delay in development is a direct result of an injury, surgery or, as a result of a treatment that is the type that is covered by this Plan.
2) This benefit is payable up to a maximum of 60 outpatient visits/person per calendar year and/or 60 days/person per calendar year in an inpatient facility/unit.
3) An admission to an Inpatient Facility requires precertification. Refer to the Utilization Management chapter for more information on precertification.
4) No coverage for Out-of-Network use of an Inpatient Facility.

Q. **Home Health Care and Home Infusion Therapy Services**

1) Part-time, intermittent Skilled Nursing Care services and Medically Necessary supplies to provide Home Health Care or home infusion services. In-network 80% after deductible met; Out-of-Network 50% after deductible met.
2) Home health aide services are covered if provided for the direct care of the patient and the services are intermittent and part-time (duration not to exceed 16 hours per day typically on less than a daily basis).
3) The annual maximum benefit for Skilled Nursing Care services and supplies to provide Home Health Care and home infusion service is 100 visits per person. Medication administered by infusion is not subject to this maximum.

R. **Hospice**

1) Hospice services include inpatient hospice care and outpatient hospice when the patient meets the definition for Hospice in the Definitions Article. In-Network 80% after deductible met; Out-of-Network 50% after deductible met.
2) **Inpatient hospice admission requires precertification to avoid a financial penalty,** by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.

S. **Hospital Services (Inpatient)**

1) Hospital room and board (including general nursing services).
2) Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms.
3) Specialty care units (e.g. intensive care unit, cardiac care unit).
4) Lab/x-ray/diagnostic services.
5) Related Medically Necessary ancillary services (e.g. prescriptions, supplies).
6) Newborn care.
7) Hospital services: In-network 80% after deductible met; Out-of-Network 50% after deductible met.
8) **All Elective inpatient hospital admissions, including transplants and spinal procedures, require precertification to avoid a financial penalty,** by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.

T. **Laboratory (Outpatient/Office)**

1) Includes pre-admission testing. In-network 80% after deductible met; Out-of-Network 50% after deductible met.

2) All out-patient drug testing claims will be covered subject to the Preferred Provider Organization (PPO) medical necessity review and criteria. Further, the Trust Fund has adopted the PPO's out-patient drug testing policy for medical necessity determinations, as may be amended periodically.

U. **Mammography Benefit**

See the Preventive services section below for information on screening mammography.

V. **Maternity Services**

1) Hospital and Birth (Birthing) Center charges and Physician and Midwife fees for Medically Necessary services.

2) For all females, prenatal and postnatal office visits obtained from an In-Network provider are payable at no cost to you. Normal plan cost-sharing applies to all other maternity related services including ultrasounds and delivery fees. When an In-Network provider submits a bill to the plan with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses.

3) Pregnancy benefits are provided only for an eligible female Employee or legal Dependent spouse. Prenatal/postnatal office visits and Health Reform mandated preventive services are covered for a pregnant Dependent child. No coverage is provided for prenatal ultrasounds or delivery expenses of Dependent children.

4) **Hospital Length of Stay of 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 caesarean section. The length of stay begins at the time of delivery if the delivery takes place in a Hospital. If the delivery does not take place in a Hospital, the length of stay begins once the mother and newborn are admitted to the Hospital as inpatients. The mother and newborn are not required to stay 48/96 hours if the attending provider, after consulting with the mother, decides to discharge the mother and newborn earlier.

5) Authorization is required for a maternity stay that exceeds the standard stay (standard stay is up to 48 hours following a vaginal delivery and 96 hours following a caesarean section). Such authorization must be obtained from the Utilization Management Company within 48 hours of expiration of the standard stay.

6) 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 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.

7) Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as noted on the Durable Medical Equipment row of this Schedule.

8) The Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider while breastfeeding, at 100%, no deductible, when provided by an in-network provider.

9) While obstetrical ultrasounds may be part of routine prenatal care, normal radiology cost-sharing applies to ultrasound services. See the Radiology row of this Schedule.

10) Prenatal and postnatal office visits, lactation counseling and Health Reform mandated preventive services for pregnant females has no cost-sharing when performed by in-network providers. All other In-Network covered services payable at 80% coinsurance after the deductible is met. Out-of-Network providers payable at 50% coinsurance after the deductible is met.

W. **Non-Durable Supplies**

1) Coverage is provided for medically necessary non-durable supplies dispensed and used by a Physician or health care practitioner in conjunction with treatment of the covered individual. Non-durable means 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, plastic tubing, cleansing solutions, etc. In-network 80% after deductible met; Out-of-Network 50% after deductible met.

2) Coverage is provided for up to a 31-day supply of home/personal use non-durable supplies in these situations:
   - 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.

3) Diabetic supplies (e.g., insulin syringes, test strips, lancets) are covered under the Drugs: Outpatient Retail and Mail Order Prescriptions section of this Article.

X. **Non-Emergency Services Subject to the No Surprises Act**

1) With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by an Out-of-Network provider at an In-Network Health Care Facility, the items or services are covered by the plan:
   a) With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network provider,
   b) By counting any cost-sharing payments made by the participant or beneficiary toward any In-Network deductible and In-Network out-of-pocket maximums applied under the Plan (and the In-Network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network provider.

2) Notice and Consent Exception-
   a) Non-emergency items or services performed by an Out-of-Network provider at an In-Network facility will be covered based on your Out-of-Network coverage if
      - At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network providers listed; and
      - The participant or beneficiary gives informed consent to continued treatment by the Out-of-Network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-Network provider may result in greater cost to the participant or beneficiary.
   b) The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network provider satisfied the notice and consent criteria and therefore these services will be covered:
      - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network provider
      - With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the recognized amount for the items and services, and

With cost-sharing counted toward any In-Network deductible and In-Network out-of-pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an In-Network provider.

Y**. Nutritional Counseling**

1) In accordance with Health Reform, for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors the Plan covers Physician-prescribed intensive behavioral

counseling interventions to promote a healthful diet and physical activity for cardiovascular disease prevention. No charge when obtained from in-network providers. For Out-of-Network providers, after deductible met Plan pays 50% coinsurance.

Z. **Physician and Other Health Care Practitioner Services**

1) Benefits are payable when provided by a Physician or other covered Health Care Practitioner in an office, hospital, emergency room, or other covered health care facility location.

   Certain services require precertification to avoid a financial penalty, by contacting the Utilization Management Company (see the Quick Reference Chart for contact information). For more information, see the Utilization Management Program section toward the front of this document.

2) Payable professionals (Physicians and Health Care Practitioners) include:

   a) Physician (MD, DO);

   b) Surgeon (see also the definition of Surgery in the Definitions Article);

   c) Assistant surgeon, including Physician, Physician Assistant (PA), Certified Surgical Assistant, and Registered Nurse are payable if medically necessary;

   d) Anesthesia provided by Physicians and Certified Registered Nurse Anesthetists (CRNA);

   e) Pathologist; Radiologist; Podiatrist;

   f) Physician Assistant (PA); Nurse Practitioner (NP); Nurse Midwife;

   g) Second Surgical Opinion.

3) Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

4) 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.

5) Office Visit for primary care physician or specialist: In-network you pay a $20 copay per office visit charge, no deductible. All other services performed and billed during an office visit the Plan pays 80% after deductible met. All other covered in-network professional fees: the Plan pays 80% coinsurance after deductible met. Out-of-Network: the Plan pays 50% coinsurance after deductible met.

AA. **Preventive Services for Children and Adults**

The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control and Prevention (CDC). These websites (periodically updated) list the types of payable preventive services (such as immunizations, mammogram, pap smear, colonoscopy with polyp removal):

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.hrsa.gov/womensguidelines/.
- http://www.cdc.gov/vaccines/schedules/hcp/index.html
- http://www.uspreventiveservicestaskforce.org/BrowseRec/Index

1) In addition to the wellness services listed on the websites above, the Plan will pay for these wellness services: well child visits, an annual wellness/physical exam for adults, well woman office visits, annual prostatic specific antigen (PSA) lab test for men age 40 and older, and screening mammogram for women at any age. Females are permitted to receive an annual routine gynecology (GYN) health exam in addition to the annual routine preventive health exam. Preventive services are payable without regard to gender assigned at birth, or current gender status.

2) In accordance with Health Reform, 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..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.

3) Preventive services are covered without cost-sharing when obtained from in-network providers. Out-of-Network: the Plan pays 50% coinsurance after deductible met.

4) Certain prescription and non-prescription drugs, required to be covered in compliance with Health Reform, are available through the Outpatient Prescription Drug program. (see Section J in this Article.) See Section J in this Article for information on payment for certain over-the-counter (OTC) drugs.

5) **Immunizations/Vaccinations Available from the Retail Pharmacy**: The Plan covers immunizations recommended by both Health Reform regulations and in accordance with the Centers for Disease Control (CDC). There is no cost-sharing when these are obtained from an in-network retail pharmacy or during an in-network physician office visit.

6) 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. Preventive services are those services performed for screening purposes when the individual does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the individual has a condition or an active symptom of a condition. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive.

7) If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.

8) 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 deductible/copay/coinsurance. Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient’s medical diagnosis are covered, subject to the Plan’s Deductibles, Coinsurance or Copayments, and all other Plan provisions.

9) If there is no network provider who can provide the Health Reform required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing.

BB. **Radiology (X-rays), Nuclear Medicine, Radiation Therapy (Outpatient/Office).**

1) Includes pre-admission testing.

2) **Outpatient radiology imaging studies like CT, MRI and PET scan require precertification** to avoid a financial penalty, by contacting the UM Company (contact information is on the Quick Reference Chart in the front of this document). See also the Utilization Management section toward the front of this document.

3) In-network 80% after deductible met; Out-of-Network 50% after deductible met.

CC. **Reconstructive Services and Breast Reconstruction after Mastectomy.**

1) The Plan complies with the Women's Health and Cancer Rights Act that indicates that for any Eligible Person 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.

2) Other reconstructive surgery is payable only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, congenital anomaly that causes a functional defect, or results from a prior covered therapeutic procedure.

3) Benefits are payable: In-Network 80% after deductible met; Out-of-Network 50% after deductible met.

DD. **Rehabilitation Therapy Services (Physical, Occupational and Speech Therapy; Cardiac Rehabilitation and Pulmonary Rehabilitation).**

1) Short term **active, progressive** rehabilitation therapy services (occupational, physical or speech therapy) are payable when performed by licensed or duly qualified therapists as ordered by a Physician.

   In-network 80% after deductible met; Out-of-Network 50% after deductible met. No coverage for Out-of-Network use of an inpatient rehabilitation facility.

2) Inpatient rehabilitation services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility are payable for short term, **active, progressive** rehabilitation therapy services **that cannot be provided in an outpatient or home setting.**

   Inpatient rehabilitation facility admission requires precertification to avoid a financial penalty, by contacting the Utilization Management Company (see the Quick Reference Chart for contact information). See also the Utilization Management section toward the front of this document.

   No coverage for Out-of-Network use of an inpatient rehabilitation facility.

3) Medically necessary speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist.

4) Maintenance rehabilitation and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation in the Medical Exclusions Article. See the definition of Rehabilitation Therapy Services in the Definitions Article.

5) Other Short-Term Active, Progressive Rehabilitation Services (Cardiac & Pulmonary Rehabilitation) are payable under the supervision of qualified medical personnel capable of treating cardiac or pulmonary 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.

EE. **Skilled Nursing Facility (SNF) and Subacute Facility.**

1) Services must be ordered by a Physician.

2) Skilled Nursing Facility and Subacute Facility confinement is payable up to 60 days per person per Calendar Year, for either skilled or subacute care. Subacute facility also called Long Term Acute Care (LTAC) Facility.

3) **Admission to a Skilled Nursing Facility requires precertification** to avoid a financial penalty, by contacting the Utilization Management Company (see the Quick Reference Chart for contact information). See also the Utilization Management section toward the front of this document.

4) In-network 80% after deductible met; Out-of-Network: not covered.

FF. **Temporomandibular Joint Syndrome/Dysfunction (TMJ) Services**

1) Office visit for primary care physician or specialist: In-network you pay a $20 copay per visit charge, no deductible. All other In-network Facility and Professional fees: 80% after Deductible met. Out-of-Network paid at 50% after deductible met.

2) The first $500 for non-surgical services per person per calendar year and $1,500 for surgical services per person per calendar year is payable at the usual coinsurance after the deductible is met, in or out-of-network; thereafter the Plan pays 10% of eligible expenses and these eligible expenses do not apply to the Plan's out-of-pocket limit.

GG. **Transplantation Services (Human Organ and Tissue)**

1) Transplant services including pre-transplant workup tests **require precertification** by calling the Utilization Management (UM) Company at their phone number listed on the Quick Reference Chart in the front of this document. For more information, see the Utilization Management Program section toward the front of this document. The UM Company can also tell you the location of the In-Network Transplant Centers of Excellence.

2) Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue including bone marrow, stem cells, cornea, heart, intestine, kidney, liver, lung(s), or pancreas, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.

3) Benefits are also payable for organ or tissue testing, procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or non-living donor.

4) Reasonable and necessary expenses incurred by a donor who is covered by this Plan, are payable. Reimbursement for in-network donor expenses is at 100% without any Deductibles and Coinsurance applicable to those donor expenses.

5) Reasonable and necessary expenses incurred by a donor who is not covered by this Plan, are payable, but only to the extent the donor is not covered by the donor's own insurance or health care plan. Reimbursement for in-network donor expenses is at 100% without any Deductibles and Coinsurance applicable to those donor expenses.

6) In-network transplant office visits charge for primary care physician or specialist you pay $20 copay per visit charge, no deductible. Other in-network transplant benefits are payable at 80% after the deductible is met.

7) The first $50,000 of eligible transplant expenses, including donor expenses, performed Out-of-Network are paid at 50% after the deductible is met, thereafter the Plan pays 10% of eligible expenses. No out-of-network transplant expenses accumulate to the out-of-pocket limit.

8) **Transplant-related travel benefits** for a transplant recipient who needs to travel to an in-network transplant facility that is more than 100 miles from their residence are payable only when pre-approved by the Utilization Management Company and when using in-network providers, as follows:

   a) Transplant-related travel expenses, including transportation, and lodging (up to $50 per person per day) for the patient and one family member or companion (and as needed for a live donor) are payable (reimbursable) to a maximum of $10,000 per transplant.

b) Reimbursement for travel expenses is at 100% up to the benefit maximum without any Deductibles and Coinsurance applicable to those travel expenses.

c) Reimbursement is available for round trip “coach” airfare to travel to/from the transplant facility, and up to a maximum of $250 per day for lodging and meals received during the pre-operative work-up, transplant operation, and post-transplant treatment phases.

d) Receipts are required when submitting lodging and travel expenses for payment consideration. The following expenses will not be reimbursed by the Plan: meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and expenses for persons other than the patient and his/her designated family member/travel companion.

e) No travel benefit for use of out-of-network providers.

ARTICLE V-B – MEDICAL EXCLUSIONS

Section 1. Overview

The following is a list of services and supplies or expenses **not covered by the Medical Plan**. The Trustees or their designee, to whom responsibility for the administration of the Medical 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.

A. **GENERAL EXCLUSIONS (applicable to all medical services and supplies)**

1) **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Trustees or their designee.

2) **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports/medical records, bills disability/sick leave claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone call, e-mailing charges, prescription refill charges, disabled/handicapped plates/automotive forms/ interest charges, late fees, mileage costs, provider administration fees concierge/retainer agreement/membership fees and/or photocopying fees.

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: educational services, supplies or equipment, including, but not limited to computers, computer devises/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory aids, speech aids/synthesizers, programs to assist with auditory perception or listening/learning skills, vision therapy, auditory or auxiliary aids such as communication boards, listening systems, device/programs/services for developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., special education and associated cost in conjunction with sign language education for a patient or family members and implantable medical identification/tracking devices, even if they are required because of an Injury, Illness or Disability of an Eligible Person.

4) **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by the Employer, or if benefits are otherwise provided under this Plan or any other plan that the Employer contributes to or otherwise sponsors, such as HMOs.

5) **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation, as described in the Medical Benefits Article.

6) **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Trustees or their designee to exceed the Allowed Charge as defined in the Definitions Article, except in the case of No Surprises Act Services.

7) **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 tortuous or wrongful act of that third party. See the Acts of Third Parties Article of this document for an explanation of 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.

8) **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical and/or dental program; or after the date the patient's coverage ends.

9) **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Trustees or their designee to be Experimental and/or Investigational as defined in the Definitions Article of this document.

10) **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.

11) **Illegal Act:** Expenses incurred by any Eligible Person for injuries resulting from or sustained as a result of commission, or attempted commission by the Eligible Person, of an illegal act that the Trustees or their designee determine in their 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 Eligible Person. The Trustees' discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Eligible Person (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved. This section shall not be construed to exclude coverage of treatment for injuries that result from an act of domestic violence or the commission or attempted commission of a felony is the direct result of an underlying health factor.

12) **Medically Unnecessary Services:** Physical exams, services or supplies determined by the Trustees or their designee not to be medically necessary as defined in the Definitions Article of this document.

13) **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 an Eligible Person, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc.

14) **No-Cost Services:** Expenses for services rendered or supplies provided for which an Eligible Person 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.

15) **No Physician/Health Care Practitioner Prescription:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician or Health Care Practitioner.

16) **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging and related expenses) of a Health care Provider, Eligible Person or family member of an Eligible Person, unless those travel expenses are related to a Plan-approved transplant as outlined under Transplantation in the Schedule of Medical Benefits in this document or under an approved alternate care plan in conjunction with case management.

17) **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by Eligible Persons 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 Eligible Person was not covered by workers' compensation insurance, or if the Eligible Person's rights under workers' compensation or occupational disease or similar law were waived or qualified.

18) **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Eligible Person is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, telephone, barber or beautician services, housecleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

19) **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 Trustees or their designee.

20) **Medical Students, Interns:** Expenses for the services of a medical student or intern.

21) **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 on a stand-by basis.

22) **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 or when the Active

Employee is on temporary work assignment for a Participating Employer at a location outside the United States.

23) **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Eligible Person as a result of failure to comply with medically appropriate treatment, as determined by the Trustees or their designee.

24) **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if the Eligible Person leaves the facility against the medical advice of the attending Physician within 72 hours after admission.

25) **Travel Contrary to Medical Advice:** Expenses incurred by any Eligible Person during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Eligible Person.

26) **Telephone Calls:** Expenses for certain telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management company, or any representative of the Plan for any purpose whatsoever, including, without limitation: Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of an Eligible Person; consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new 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, not including advice provided by an in-network provider as part of a therapy session.

27) **Internet/Virtual Office/Telemedicine Services:** Expenses related to an Out-of-Network/Non-Contracted online internet consultation with an Out-of-Network Physician or other Health Care Practitioner, also called a virtual office visit/consultation, 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.

28) **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) **Self-Inflicted Injury or Attempted Suicide:** Expenses incurred by any Eligible Person arising from an attempt at suicide or from a self-inflicted Injury or Illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition. This section shall not be construed to exclude coverage of treatment for injuries that result from an act of domestic violence.

31) Expenses related to **complications of a non-covered service**.

32) Surcharges: any **surcharge fees resulting from state laws that are the patient's responsibility** (e.g. New York Health Care Reform Act).

33) 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.

34) 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.

35) **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.

36) 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.

37) Non-human gene therapy (see the definition of "Gene Therapy").

38) Expenses for hypnosis, hypnotherapy and/or biofeedback.

B. **EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES**

38) **Allergy/Alternative/Complementary Health Care Services Exclusions**

a. Expenses for acupuncture and/or acupressure.

b. 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.

c. Expenses for prayer, religious healing, or spiritual healing.

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

e. Expenses for experimental/investigational allergy treatments including but not limited to sublingual (under the tongue) drops/oral antigen, rhinophototherapy, repository emulsion therapy (a form of therapy where certain materials are placed inside the body to improve allergies).

39) **Behavioral Health Care Exclusions**

a. 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, vocational disabilities;

2) Medically Necessary psychological and neuropsychological testing is considered for coverage.

3) Court-ordered behavior health care services (except when medically necessary) or custody counseling;

4) Counseling for adoption, marriage/couples counseling, transsexual, gender reassignment, or sexual dysfunction;

5) Tests and related expenses to determine the presence or degree of a person's dyslexia or learning disorder.

39) **Corrective Appliances, Durable Medical Equipment, and Non-durable Supplies Exclusions**

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

b. For these purposes, 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, Orthotic Devices and supplies needed 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 an undressing.

e. Expenses for Non-durable Supplies, except as payable under Non-durable Supplies in the Schedule of Medical Benefits.

40) **Cosmetic Services Exclusions**

a. 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 reconstructive services after a mastectomy), elimination of redundant skin of the abdomen, surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance, treatment of varicose veins or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Trustees or their designee.

b. The Medical Program **does** cover Medically Necessary Reconstructive Services. To the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits in this document. Note that inpatient admissions require precertification. Plan Participants may use the Plan's Precertification procedures to determine if a proposed surgery or service will be considered cosmetic surgery or Medically Necessary Reconstructive Services.

41) **Custodial Care Exclusions**

a. Expenses for Custodial Care as defined below, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, personal care attendant, sitter/companion service, except when Custodial Care is provided as part of a covered Hospice program or is provided during a covered hospitalization. For these purposes, Custodial Care means care and services given mainly for personal hygiene or to perform the activities of daily living.

b. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Trustees or their designee to be Medically Necessary. However, 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.

42) **Dental Services Exclusions**

a. Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, Illness or Injury affecting the mouth or another part of the body.

b. Expenses for dental services may be covered (as noted in Article V-A) 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. The medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Board of Trustees 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. The dental treatment provider is encouraged to seek pre-treatment approval from the Administrative Office for dental work.

c. Expenses for the diagnosis, treatment or prevention of Temporomandibular Joint (TMJ) Dysfunction or Syndrome in excess of the TMJ benefit limit shown in the Schedule of Medical Benefits.

d. Expenses for orthognathic services/surgery for treatment of prognathism, retrognathism and TMJ (in excess of the TMJ benefits limit shown in the Schedule of Medical Benefits) and other cosmetic reasons.

e. Expenses for oral surgery to remove teeth including wisdom teeth, gingivectomies, treatment of dental abscesses, and root canal (endodontic) therapy.

43) **Drugs, Medicines and Nutrition Exclusions** (such as are available from the Prescription Drug Program)

a. Pharmaceuticals requiring a prescription that have not been approved by the U.S. 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").

b. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin and certain over-the-counter(OTC) medication prescribed by a Physician or Health Care Practitioner that are covered without cost-sharing in accordance with Health Reform regulations.

c. Drugs requiring a prescription by state law, but not by federal law, are not covered.

d. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization, and except for prenatal vitamins or minerals requiring a prescription and except certain over-the-counter(OTC) medication prescribed by a Physician or Health Care Practitioner, to be covered without cost-sharing in accordance with Health Reform regulations.

e. Naturopathic, naprapathic or homeopathic substances.

f. Drugs, medicines or devices for:

   - Drugs to enhance athletic performance such as anabolic steroids;
   - Dental products such as fluoride preparations and products for periodontal disease, except certain drugs/services prescribed by a Physician or Health Care Practitioner, to be covered without cost-sharing in accordance with Health Reform regulations;
   - Hair removal or hair growth products (*i.e.* Propecia, Rogaine, Minoxidil, Vaniqa);
   - Growth hormone;

- Sexual/erectile dysfunction;
- Skin treatment products are excluded (except Retin A and Accutane that are payable to age 26);
- Vitamins, except prenatal vitamins and except and certain vitamins prescribed by a Physician or Health Care Practitioner, to be covered without cost-sharing in accordance with Health Reform regulations;
- Weight control or anorexiants (*i.e.* Xenical, Contrave, Wegovy, Saxenda, Zepbound);
- 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;
- Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, Health Care Practitioner's office or other Health Care Facility;

Durable Medical Equipment Exclusions: See the Corrective Appliances, Durable Medical Equipment, and Non-durable Supplies Exclusions section above.

44) **Fertility and Infertility Services Exclusions**

a. Expenses for surrogate parenting, cryostorage of eggs or sperm, adoption, infertility donor expenses, fetal implants, reversal of sterilization procedures, and fetal reduction services are excluded.

b. Prenatal services, maternity services and prescription drug services related to a pregnancy incurred by a covered person acting as a surrogate mother (gestational carrier) are not covered charges. For the purpose of this plan, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her Spouse, if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth.

45) **Foot/Hand Care Exclusions**

a. Expenses for routine foot care (including, but not limited to, trimming of toenails, removal or reduction of corns and calluses, removal of 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, unless the Trustees or their designee determines such are to be Medically Necessary. Routine foot care is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

46) **Genetic Testing and Counseling Exclusions**

a. **Genetic Testing:** The following expenses for genetic tests are not covered, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics. (Certain genetic tests are covered as listed as payable in the Genetic Testing row in the Schedule of Medical Benefits.) Genetic services that are **not covered** include:
   i. **Pre-parental genetic testing** (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children);
   ii. Expenses for **Pre-implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
   iii. 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. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the medically necessary treatment of a plan participant;
   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, experimental or investigational**.

See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan.

Plan Participants should contact the Utilization Management program or Administrative Office for assistance in determining if a proposed Genetic Test will be covered or excluded.

b. **Genetic Counseling:** Expenses for genetic counseling are not covered, unless these three conditions are met: is ordered by a Physician, performed by a qualified genetic counselor and performed in conjunction with a genetic test that is payable by this Plan.

47) **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.

48) **Hearing Care Exclusions**

a. Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including implantable hearing devices, except medically necessary cochlear implants.

b. Special education and associated costs in conjunction with sign language education for a patient or family members.

49) **Home Health Care Exclusions**

a. Expenses for any Home Health Care Agency 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 Article V-A.

b. Expenses under a Home Health Care Agency program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, or when the patient is not under the continuing care of a Physician.

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 Article V-A.

d. Expenses for transportation to or from a place outside the Eligible person's home to receive a Home Health Care service.

50) **Maternity/Family Planning/Contraceptive Exclusions**

a. **Contraception:** Expenses for non-prescription male contraceptives such as condoms.

b. **Termination of Pregnancy:** Expenses for elective induced abortion unless the attending Physician certifies that the health of the woman would be endangered if the fetus were carried to term or where medical complications arise from an abortion.

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

d. Expenses related to the **prenatal ultrasounds and delivery expenses associated with a pregnant Dependent child or maternity and delivery expenses associated with a surrogate mother's pregnancy**.

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

51) **Nursing Care Exclusions**

a. Expenses for services of private duty nurses are excluded.

52) **Rehabilitation Therapy Services Exclusions (Inpatient or Outpatient)**

a. Expenses for educational, job training, vocational rehabilitation and/or special education for sign language.

b. Expenses for massage therapy, rolfing, 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 Trustees or their 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, cognitive rehabilitation, coma stimulation programs and services.

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

e. Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering, or for childhood developmental speech delays and disorders.

f. Expenses for treatment of delays in childhood speech development unless as a direct result of an injury, surgery or for other Medically Necessary speech therapy.

g. Expenses for prolotherapy (injection of sclerosing solutions into joints, muscles, or ligaments).

53) **Sexual/Erectile Dysfunction Services Exclusions**

a. **Treatment of Sexual/Erectile Dysfunction:** Expenses for prescription drugs (*i.e.* Viagra) and/or medical or surgical treatment of sexual/erectile dysfunction or inadequacy, and any complications thereof.

b. **Sex Change Counseling, Therapy and Surgery:** Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.

54) **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/selection, organ or tissue removal, transportation, transplantation, postoperative services, drugs/medicines, and all complications thereof.

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

c. For plan participants who serve as a donor, donor expenses are not payable by this Plan unless the person who receives the donated organ/tissue is a person covered by this Plan.

55) **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), or implantable contact lenses (ICL), except ICL after surgery to remove the lens of the eye such as in a cataract extraction procedure.

b. Vision therapy (orthoptics) and supplies.

56) **Weight Management and Physical Fitness Exclusions**

a. Except as stated in the Schedule of Benefits, expenses for medical or surgical treatment of obesity (bariatric surgery) including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, skin reduction procedures/treatment and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying health condition.

b. 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 or exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless, or wearable sensors/trackers.

c. Expenses for medically necessary treatment of an eating disorder due to a mental health condition.

ARTICLE VI – DENTAL PLAN BENEFITS

Section 1. Dental Plan Benefits Overview.

Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. As an excepted benefit participants have the ability to opt out of the Dental Plan by contacting the Administrative Office.

When an Eligible Person incurs Covered Dental Expenses for Preventive/Diagnostic, Basic and Major Services which exceed the Deductible and are incurred in a Calendar Year as shown in the Schedule of Dental Benefits located toward the front of this document, and as further explained in this Article, the Fund will pay the following:

a. **Coinsurance:** The Coinsurance applies after the Deductible has been met. The coinsurance the Plan pays is:

- **100% of the Covered Dental Expenses for Preventive/Diagnostic (no deductible); and**
- **80% of the Covered Dental Expenses for Basic Services and Major Services**

b. **Deductible:**

- This Dental Plan Deductible is $100 per Eligible Person. It must be met each Calendar Year.
- The dental plan deductible is waived for preventive/diagnostic dental services.
- When three or more Eligible Persons in a family jointly incur $300 of Covered Dental Expenses used to meet their Deductibles, it will not apply to other family members for the rest of that Calendar Year.

c. **Qualified Dental Provider:** Dental benefits are payable when provided by a Qualified Dental Provider as noted below:

- **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, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.
- **Dental Hygienist:** A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, 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, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

Section 2. Covered Dental Expenses.

Eligible Persons are covered for expenses they incur for most, but not all, dental services determined by the Trustees or their designee to be **Medically Necessary**, but only to the extent that:

a. The Eligible Person is in a Plan that provides dental coverage as shown in the Schedule of Dental Benefits in this document;

b. The Trustees or their designee determine that the services are the most cost effective ones that meet acceptable standards of dental practice and would produce a satisfactory result; and

c. The charges for them are considered an Allowed Charge (defined in the Definitions Article).

Section 3. Annual Maximum Dental Benefits.

The Plan's Calendar Year Annual Maximum Dental Benefits payable for any individual covered under this Plan is outlined below and also shown in the Schedule of Dental Benefits in this document. This maximum does not include the Dental Plan Deductible or any amounts over the Allowed Charge.

- For **Plan A:** $1,000 per person per calendar year. For **Plan C:** $1,500 per person per calendar year

Section 4. Payment of Dental Benefits.

When Charges for Dental Services and Supplies Are Incurred: Dental services and supplies are considered to have been incurred on the date the services are performed or on the date the supplies are furnished. However, this rule does not apply to the following services because they must be performed over a period of time.

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) prepared for the installation.

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. **Orthodontics/Orthodontia:** Services related to orthodontia/orthodontics are **not covered**.

Section 5. Extension of Dental Coverage.

If dental coverage ends for any reason, the Plan will pay Plan benefits for Eligible Persons 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. A prosthesis (such as a full or partial denture), if the Dentist took the impressions and prepared the abutment teeth while the Eligible Person was covered, **and** installs the device within 31 days after coverage ends.

b. A crown, if the Dentist prepared the crown while the Eligible Person was covered **and** installs it within 31 days after coverage ends.

c. Root canal treatment, if the Dentist opened the tooth while the Eligible Person was covered **and** completes the treatment within 31 days after coverage ends.

Section 6. Alternative Procedures.

Often there are several ways to treat a particular dental problem that will produce a satisfactory result. The Plan will pay benefits on the procedure that meets acceptable standard of dental practice that the Trustees or their designee determine to be most cost-effective. An Eligible Person may choose a more costly procedure. However, if this is the case, the Eligible Person 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 the Eligible Person and the Eligible Person's Dentist. The pretreatment estimate procedure described below will help the Eligible Person know what benefits the Plan will pay. The Eligible Person will then be able to determine the difference (if any) that you may have to pay yourself.

Section 7. Pretreatment Estimate.

Pretreatment Estimate means an attending Dentist's report of a recommended treatment plan. The written treatment plan must list the requested procedures, diagnostic materials, and supporting x-rays including the charge for each procedure.

If the estimate for dental treatment exceeds $300, a Pretreatment Estimate should be filed with the Administrative Office before work starts.

To obtain a Pretreatment Estimate, the Eligible Person's Dentist should complete the regular dental claim form, available from the Administrative Office, and send it to the Administrative Office indicating the type of work to be performed along with pertinent x-rays and the estimated cost (valid for a 30-day period). Once it is received, the Administrative Office will review the form and then send a statement within the next 60 days showing what the Plan will pay. The Dentist may call the Administrative Office for a prompt determination of the benefits payable for a particular dental procedure.

Section 8. Prescription Drugs Needed for a Dental Purpose.

Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the Prescription Drug Benefit of the Medical Plan. Note that some medications for a dental purpose are not payable, such as periodontal mouthwash. See the Medical Exclusions Article under "Drugs" for more information.

Section 9. Covered Dental Services.

A. **PREVENTIVE/DIAGNOSTIC SERVICES (Plan pays 100% coinsurance, no deductible.)**

1) Routine oral exams;
2) Emergency palliative treatment of dental pain;
3) Complete mouth survey of x-rays (with or without bitewings) but not more than one in 36 consecutive months;
4) Individual periapical x-rays;
5) Bitewing x-rays, but not more than two series in 12 consecutive months;
6) Occlusal x-rays;
7) Extra-oral x-rays, but not more than two in 12 consecutive months;
8) Topical application of fluoride, but not more than once in 12 consecutive months;
9) Dental prophylaxis (with or without oral exams), but not more than two in 12 consecutive months;
10) Fixed space maintainers for children under age 14;
11) Removable space maintainers for children under age 14; and
12) Sealants to permanent molar teeth for children under age 14.

B. **BASIC SERVICES (Plan pays 80% coinsurance after deductible met)**

1) General anesthesia and/or intravenous sedation, when needed in connection with covered complex oral or dental surgical procedures;
2) Antibiotic drug injections;
3) Amalgam restorations;
4) Pin retention;
5) Silicate restorations;
6) Acrylic or plastic restorations;
7) Composite restorations;
8) Re-cementing of inlays and crowns;
9) Periodontal prophylaxis;
10) Periodontal scaling and root planning, but not more than two in 12 consecutive months;
11) Pulp capping; pulpotomy;
12) Occlusal equilibration (when no restoration is involved);
13) Diagnostic cast for comprehensive cases, but not more than one in 36 consecutive months;
14) Adjustment made to complete or partial denture more than one year after it was installed;
15) Repair made to complete or partial denture more than one year after it was installed;
16) Addition to partial denture to replace a natural tooth extracted while covered;

17) Relining of denture, but only if done more than one year after installed and not more than once in 24 consecutive months;

18) Laboratory service and tissue conditioning done in connection with the covered addition to a partial denture or repair or relining of a denture;

19) Repair of fixed bridge more than one year after it was installed;

20) Re-cementing of fixed bridge;

21) Extractions;

22) Biopsy of oral tissue;

23) Incision and drainage;

24) Pulp vitality tests.

25) Root canal therapy including the treatment plan, clinical procedure and follow-up care. A final restoration done in conjunction with pulp capping, pulpotomy, or root canal therapy is a separate service.

26) Apicoectomy and retrograde filling;

27) Gingivectomy; gingivoplasty; gingival curettage;

28) Osseous surgery;

29) Alveoplasty.

C. **MAJOR SERVICES (Plan pays 80% coinsurance after deductible met)**

All services listed below include temporaries and one-year follow-up care.

1) Gold foil restorations;

2) Gold inlay restorations when tooth cannot be restored by silver fillings, and five or more years after the last placement;

3) Crown restorations when tooth cannot be restored by a filling or other means, and five or more years after the last placement;

4) Crown buildups (pin retained), but only when tooth cannot be restored by crown alone;

5) Gold post and core (in addition to crown), but only for teeth that have had root canal therapy;

6) Initial installation of partials, dentures, and fixed bridges to replace teeth extracted while covered;

7) Replacement of partials, dentures and fixed bridges, but only if more than five years after the last placement and the prior appliance cannot be made serviceable.

Section 10. Unlisted Dental Service.

A charge for an unlisted service may be submitted to the Fund. The service should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature, and/or by narrative description. If the Fund accepts the charge, the benefit paid will be consistent with that for a listed service that gives adequate treatment.

Section 11. Dental Plan Exclusions.

The following is a list of dental services and supplies or expenses **not covered by the Dental Plan**. The Trustees 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.

a. **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls, interest charges, late fees and/or photocopying fees.

b. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation, or Annual Maximum Dental Benefits, as described in the Dental Plan Benefits Article.

c. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered dental services or supplies that are determined by the Trustees or their designee to exceed the Allowed Charge as defined in the Definitions Article of this document, or that exceed the scheduled charges for dental services.

d. **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 Acts of Third Parties Article.

e. **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 section on Extension of Dental Benefits in the Dental Plan Benefits Article or under the self-payment provisions of the Plan.

f. **Experimental and/or Investigational Services:** Expenses for any dental services, supplies, or drugs or medicines that are determined by the Trustees or their designee to be Experimental and/or Investigational as defined in the Definitions Article of this document.

g. **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.

h. **Illegal Act:** Expenses incurred by any Eligible Person for injuries resulting from or sustained as a result of commission, or attempted commission by the Eligible Person, of an illegal act that the Trustees determine in their 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 Eligible Person. The Trustees' discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Eligible Person (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved. This section shall not be construed to exclude coverage of treatment for injuries that result from an act of domestic violence.

i. **Medically Unnecessary Services:** Services or supplies determined by the Trustees or their designee not to be Medically Necessary as defined in the Definitions Article of this document.

j. **Non-Dentist:** Expenses for services rendered or supplies provided that are **not recommended or prescribed by a Dentist**.

k. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by Eligible Persons 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 Eligible Person was not covered by workers' compensation insurance, or if the Eligible Person's rights under the workers' compensation or occupational disease or similar law have been waived or qualified.

l. **Relatives Providing Services:** Expenses for services provided by a Dentist or dental hygienist or other Dental Care Practitioner who is the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

m. **Services Provided Outside the United States:** Expenses for dental services or supplies rendered or provided outside the United States, except for treatment for an emergency.

n. **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.

o. **Analgesia, Sedation, Hypnosis, etc.:** Expenses for analgesia, sedation, hypnosis, and/or related services provided for apprehension or anxiety. Note that covered dental expenses will include the cost of anesthesia and outpatient surgical facility fees for covered dental services, payable up to the annual maximum dental plan benefit.

p. **Cosmetic Services:** Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Trustees or their designee, including, but not limited to, bleaching/whitening of teeth, veneers, facings enamel hypoplasia (lack of development), fluorosis (tooth discoloration) and anodontia (congenitally missing tooth). However, the following will be covered if they otherwise qualify as covered dental expenses and **are not covered** under the Medical Benefits Article.

- Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
- Surgery or treatment to correct deformities caused by Sickness;
- Surgery or treatment to correct birth defects outside the normal range of human variation;
- Reconstructive dental surgery because of congenital disease or anomaly of a covered Dependent child that has resulted in a functional disorder.

q. **Drugs and Medicines:** Expenses for prescription drugs and medications that are covered under your Medical Expense Coverage, and the Plan's Prescription Drug Program.

r. **Duplicate or Replacement Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement of any lost, missing or stolen bridge, denture or orthodontic appliance other than replacements described in the Major Services section of the Schedule of Dental Benefits.

s. **Duplication of Dental Services:** If a person covered by this Plan transfers from the care of one Dentist to the care of another Dentist during the course of any treatment, or if more than one Dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one Dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.

t. **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.

u. **Hospital Expenses Related to Dental Care:** Expenses for hospitalization related to dental surgery or care. Note that covered dental expenses will include the cost of anesthesia and outpatient surgical facility fees for covered dental services, payable up to the annual maximum dental plan benefit.

v. **Implantology:** Expenses related to implantology including, but not limited to, tooth transplants or tooth implants, also referred to as dental implants or endosseous implants, that serve as artificial or replacement root structures placed into the jaw to support/anchor replacement teeth, bridgework, dentures or other dental prostheses.

w. **Periodontal Splinting:** Expenses for periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability).

x. **Personalized Bridges, Dentures, Retainers or Appliances:** Expenses for personalization or characterization of any dental prosthesis including, but not limited to, any bridge, denture, retainer or appliance.

y. **Precision or Semi-precision Instruments.**

z. **Denture Duplication:** Expenses for over-dentures (a prosthesis that gains support from one or more abutment teeth by enclosing them beneath its fitting surface).

aa. Services which most **Dentists do not endorse** or are payable by any other part of the Plan.

bb. **Repair of an Oral Birth Defect:** Expenses for the repair of an oral birth defect other than a handicapping malocclusion.

cc. **Photographs of Teeth/Gums/Oral Cavity.**

dd. **Services or Appliances Subject to Orthodontia Benefit:** Expenses for any dental services or appliances including, but not limited to items to increase vertical dimension, stabilize periodontally involved teeth, restore occlusion, stabilize tooth structure lost by wear or bruxism and harmful habits.

ee. **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a Dentist (except for services of a Dental Hygienist that are supervised and billed by a Dentist and are for cleaning or scaling of teeth or for fluoride treatments).

ff. **Treatment of Jaw or Temporomandibular Joints (TMJ):** Expenses for treatment, by any means, or jaw joint problems including temporomandibular joint (TMJ) dysfunction, disorder or syndrome, except to the extent payable under the Schedule of Benefits, and any other craniomandibular disorders or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.

gg. Any treatment or service for which the Eligible Person has **no financial liability or that would be provided at no cost** in the absence of dental coverage.

hh. **Bite Registration or Analysis**.

ii. **Bacteriologic studies and susceptibility testing for dental caries** (cavities) not covered.

jj. **Services that are an integral component of a covered treatment (e.g. unbundling)**.

kk. **Fees charged for infection control procedures** and compliance with Occupational Safety and Health Administration (OSHA) requirements.

ll. **Expenses related to complications of a non-covered service.**

Section 12. Definitions Pertaining to Dental Benefits

A. **Appliance (Dental):** A device to provide or restore function or provide a therapeutic (healing) effect.

- **Fixed Appliance:** A device that is cemented to the teeth or attached by adhesive materials.
- **Prosthetic Appliance:** A removable device that replaces a missing tooth or teeth.

B. **Bitewing X-Rays (Dental):** Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

C. **Bridge, Bridgework (Dental):** *Fixed:* A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more Pontics and one or more retainers (Crowns or Inlays). The patient cannot remove the prosthesis. *Removable:* A prosthesis that replaces one or more teeth and which is held in place by clasps. The patient can remove the prosthesis.

D. **Crown (Dental):** The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

E. **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 includes outpatient prescription drugs prescribed by a dentist, physician or health care practitioner for a dental purpose such as fluoride tablets. 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. Dental services and supplies are **not covered** under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise in the Schedule of Medical Benefits.

F. **Dental Care Provider:** A Dentist, or Dental Hygienist or other Health Care Practitioner or Nurse as those terms are specifically defined in this Article of the document, who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and 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 Employee.

G. **Dental Hygienist:** A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, 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, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

H. **Dental Subspecialty Areas:**

Subspecialty	Services related to the diagnosis, treatment or prevention of diseases related to:
Endodontics	the dental pulp and its surrounding tissues.
Implantology	attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	extractions and surgical procedures of the mouth.
Orthodontics	abnormally positioned or aligned teeth.
Pedodontics	treatment of dental problems of children.
Periodontics	structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	construction of artificial appliances for the mouth (Bridges, Dentures, Crowns).

I. **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, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

J. **Fluoride (Dental):** A solution applied to the surface of teeth or a prescription drug (usually in pill form) to prevent dental decay.

K. **Inlay(Dental):** A Restoration made to fit a prepared tooth cavity and then cemented into place. See the definition of Restoration.

L. **Onlay (Dental):** An Inlay Restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

M. **Partial Denture (Dental):** A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.

N. **Pontic (Dental):** The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

O. **Prophylaxis (Dental):** The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a Dentist or Dental Hygienist.

P. **Prosthesis (Dental):** An artificial replacement of one or more natural teeth and/or associated structures.

Q. **Restoration (Dental):** A broad term applied to any filling, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

ARTICLE VII – VISION PLAN BENEFITS

Section 1. Overview Vision Plan Benefits.

Vision plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. As an excepted benefit participants have the ability to opt out of the Vision Plan by contacting the Administrative Office.

When an Eligible Person (as shown in the Plan Benefits Chart) incurs covered expenses for eligible vision benefits received from a licensed vision provider (e.g. ophthalmologist, optometrist, optician), the Plan will pay the lesser of the:

A. Actual charge; or

B. Maximum amount shown in the Schedule of Vision Benefits.

These charges must be incurred while this Vision Plan benefit is in force for an Eligible Person.

No deductible applies to Vision Plan benefits.

Section 2. Schedule of Vision Benefits.

The Vision Plan benefits are described in the Schedule of Vision Benefits (located toward the front of this document).

A. An annual Vision Exam (per 12 consecutive months) is payable for individuals age 18 years and older at 100% up to $32.50.

B. An annual Vision Exam (per 12 consecutive months) is payable for individuals under age 18 years at 100%.

Section 3. Vision Plan Exclusions and Limitations.

This Vision Plan does not cover:

A. Replacement of eyeglasses or contact lenses unless an exam shows that a vision change requires a lens change;

B. Sunglasses, safety glasses or goggles;

C. Tinting, coloring or shading of lenses;

D. Charges for services or materials not named in this benefit;

E. Exams which are:

   1. Required for employment; or

   2. Provided by the Eligible Person's employer.

ARTICLE VIII – COORDINATION OF BENEFITS (COB)

Section 1: Effect on Benefits.

This provision will apply only to a person covered under This Plan and one or more other Plans. It applies during any one Claim Determination Period when the combined benefits of This Plan and all other Plans would exceed 100% of Allowable Expenses.

The Plan that is required to pay benefits first is called the primary Plan. If This Plan is not primary, then its benefits will be reduced so that the total payable by all Plans does not exceed 100% of Allowable Expenses. Benefits payable under another Plan include those that would have been paid if a claim had been filed.

Section 2: Definitions.

The following are terms used in this Article:

a. **Allowable Expense** means any necessary Allowed Charge expense which is covered at least in part by one or more other Plans on the person for whom claim is filed. When a Plan provides benefits in services rather than cash, the reasonable cash value of each service will be counted as both an Allowable Expense and a benefit paid.

b. **Claim Determination Period** means a calendar year.

c. **No-Fault Group, Group-type and Individual Automobile Coverage Plans** means all automobile coverage plans which provide payment for hospital and medical expenses from injuries received in motor vehicle accidents without regard to fault. This term does not include benefits paid to a person who is a third party. The term Plan will apply separately to:
   - each Plan, contract or other arrangement for benefits or services;
   - that part of any such Plan, contract or arrangement which reserves the right to consider other plans in computing benefits;
   - that part of any such Plan, contract or arrangement which does not reserve that right

d. **Plan** means any plan for benefits or services for medical or dental care or treatment provided by:
   - group, group-type, franchise or blanket coverage;
   - group or group-type hospital indemnity plans which exceed a benefit of $50 per day;
   - service plan contracts, group practice, individual practice and other prepayment coverage;
   - labor-management trusteed plans;
   - union welfare plans;
   - employer organization plans;
   - employee benefit organization plans;
   - no-fault group, group-type and individual automobile coverage plans and traditional automobile "fault"-type contracts;
   - government programs and coverage required or provided by law, except Medicaid.

   The term Plan does not include student accident coverage; or individual or family policies.

e. **Student Accident Coverage** means coverage:
   - which covers grammar and high school students for accidents only, including athletic injuries;
   - which provides coverage either on a 24-hour basis or "to and from school"; and
   - for which the parent pays the entire premium.

f. **This Plan** means all benefits of this Plan, except AD&D, and Disability Income; if included in your Plan.

Section 3: How Coordination of Benefits Works.

When the use of this provision reduces the total amount of benefits payable under This Plan, the reduced amount will be applied in proportion to each benefit payable. The reduced amount will also be charged against the applicable benefit limit.

When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of allowable expenses less whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the calendar year for each claim as it is processed had it been the Plan that paid first.

The first of the following rules that applies will be used to determine which Plan is primary:

1. A plan with no coordinating provision is always the primary plan. However, if an actively employed Eligible Person age 65 or older, has elected Medical Benefits under this Plan according to his or her applicable class, benefits under this Plan for that person will be primary to benefits payable under Medicare. If the Eligible Dependent Spouse age 65 or older, of an actively employed Eligible Person of any age, has elected medical benefits under this Plan according to his or her applicable class, benefits under this Plan for that Dependent Spouse will be primary to benefits payable under Medicare.

   Age 65 or older means a period beginning with the first day of the month in which a person attains age 65. An individual attains a particular age on the day preceding his or her birthday.

2. If a person has Personal group-type coverage, but is also covered as a Dependent under another group-type Plan, the Personal coverage is primary.

3. If a child is covered as the Dependent of more than one person (other than legally separated or divorced parents), the benefits under the Plan of the person whose birthday falls earlier in a calendar year will be primary; however:

   a. if both persons have the same birthday, then the Plan in force longer will be primary; or

   b. if one of the Plans is not subject to this rule, then that Plan will determine the order of benefits.

4. If a Dependent child's parents are legally separated or divorced:

   a. if the parent with custody has not remarried, the benefits under that parent's Plan will be primary; or

   b. if the parent with custody has remarried:

      (1) that parent's Plan will pay benefits before the stepparent's Plan; and

      (2) the stepparent's Plan will pay benefits before the Plan of the parent without custody;

      however, if by court order one parent must provide financial support for the child's medical, dental or other health care expenses, then the benefits under that parent's Plan will be primary.

5. If a person is covered under two or more Plans that contain a coordinating provision:

   a. as a Retiree or laid-off person or as the Dependent of such a person under one Plan; and

   b. as an active Employee or as the Dependent of an active Employee under another Plan;

   the benefits of the Plan covering the Retiree or laid-off person or the Dependent of such a person will be determined after the benefits of the other Plan or Plans. This rule will not apply if one of the Plans does not have a provision regarding Retirees or laid-off persons.

6. If none of the above rules applies, the Plan in force longer will be primary, if:

   a. the above rules would require This Plan to determine benefits first; and

   b. the other Plan has the same rules;

   the Fund will proceed with paying benefits under This Plan first.

Section 4: Right To Receive and Release Information.

For the purpose of this provision, or a similar one of another Plan, the Fund may exchange data with any other coverage Fund, organization or person about the person for whom claim is made. No consent or notice is required. A person claiming benefits under This Plan must give the Fund the data needed to carry out this provision.

Section 5: 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.

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.

Section 6: How Much This Plan Pays When It Is Secondary to Medicare.

A. **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 determines the Allowed Charges payable. Those Allowed Charges will be reduced so that the sum of benefits paid under this Plan and Medicare will not exceed the total of such Allowed Charges. Benefits are payable under this Plan after Medicare benefits have been paid whether or not such Eligible Participant is disabled and not in an active employment status and is under or over age 65, (other than as specified for an End Stage Renal Disease (ESRD) beneficiary as noted above in paragraph D).

B. **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 coordinate benefits based on the Medicare-approved amount and will pay the benefits provided 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 <u>NOT</u> provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

C. **When Covered by this Plan and <u>Eligible for but Not Covered</u> by Medicare:** When the Covered individual is covered by this Plan and is also **eligible for, but is not enrolled in Medicare Parts A, B and/or D**, this Plan will coordinate benefits estimating a Medicare payment of 80% of covered services then apply this Plan's Medicare coordination of benefits method as stated in step 1 above.

D. **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 under which he or she 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.

E. **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, the following explains how this Plan and Medicare will coordinate that dual coverage. For Medicare eligible Active Employees and individuals no longer actively employed but still receiving benefits based on hours accumulated when they were working and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary. For more information on Medicare Part D refer to www.medicare.gov or contact the Administrative Office.

Section 7: Coordination with Other Government Programs.

A. **Medicaid**: If an individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

B. **TRICARE**: If a Covered Dependent is covered by both this Plan and the TRICARE Program that provides health care services to dependents of active armed services personnel, 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 the 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.

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.

Section 8: Workers' Compensation.

A. This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law.

B. 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. However, before such payment will be made, the individual must execute a reimbursement agreement acceptable to the Plan Administrator or its designee.

Section 9: Facility of Payment.

When payments have been made under other Plans that should have been made under This Plan, the Fund has the right, at its sole discretion, to compensate any other organization to achieve the goal of this provision. Such payments will count as benefits paid and will discharge the Fund's liability under This Plan for their amount.

Section 10: Right of Recovery.

Whenever the Fund has paid more toward Allowable Expenses than it should have by reason of this provision, the Fund will have the right to recover the excess from the person(s) it has paid or for whom it has paid, and from other coverage companies or organizations with Plans covering the same person.

ARTICLE IX – ACTS OF THIRD PARTIES

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 Article V-B Medical Exclusions), 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) 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;
   (e) all information discovered by the covered Employee and/or covered Dependent(s) or their attorney concerning the insurance coverage of the third party;
   (f) 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;
   (g) 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
   (h) 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 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 X – HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Section 1: Establishment of HRA and Legal Status.

This portion of the Plan is designed to permit an Active Employee to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the Health Reimbursement Arrangement (HRA). The HRA benefits described in this document are available to Participants whose Local Unions have negotiated a contribution for those benefits, and those who are otherwise eligible under Section 2 "Eligibility," below.

This HRA Plan is intended to qualify as an employer-provided medical (health) reimbursement plan under Code §§105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses, including COBRA self-pay premiums, reimbursed under the Plan are intended to be eligible for exclusion from HRA Participants' (including COBRA Participants) gross income under Code §105(b).

The Plan is intended to comply with the requirements of IRS Notice 2013-54, the exception the Affordable Care Act's annual limit rule and preventive services mandate that is available for HRAs that are integrated with group health plans that provide minimum value, and shall be interpreted to accomplish that objective.

Section 2: Eligibility for HRA Account.

Initial Eligibility for the HRA Plan will not begin until the employee is eligible for the National Roofers Union and Employers Joint Health and Welfare Plan. Eligibility will continue until the HRA Plan terminates, the HRA Account balance reaches zero, the HRA Account is in Suspension or forfeited, or the Participant effectuates an Opt-Out.

An HRA Participant (and his/her eligible dependents) may not participate in the HRA Account unless the HRA Participant (and his/her eligible dependents) is **actually enrolled in** a group health plan that provides minimum value pursuant to Internal Revenue Code §36B(c)(2)(C)(ii), regardless of whether the group health plan is sponsored by this Fund. A group health plan provides minimum value if the coverage is at least 60 percent (60%) of the actuarial value of a standard plan as determined by the IRS.

a. **HRA Negotiated by Local Union**. An Active Employee whose Local has negotiated for HRA contributions will be eligible for an HRA Account. Active Employees may not contribute to HRA Accounts.

b. **Proof of Coverage**. An HRA Participant who is not a Participant in the Fund for medical coverage must submit proof of other group health plan coverage providing minimum value, to be eligible to participate in the HRA. The proof of satisfactory group health coverage shall be in a manner to be determined by the Trustees.

c. **Opt-Out**. An HRA Participant is permitted on at least an annual basis, to opt-out of and waive future reimbursements from the HRA Account, in a time and manner determined by the Trustees. An HRA Participant also has the ability to opt-out upon termination of coverage under the Plan. This type of opt-out means that the HRA Participant or Retiree waives future reimbursements from the HRA Account upon termination of coverage under the Plan.

Section 3: Definitions.

Any capitalized terms used in the Plan that are not specifically defined herein, have the same meaning given in the National Roofers Union and Employers Joint Health and Welfare Plan.

a. **"Code"** means the Internal Revenue Code of 1986, as amended.

b. **"HRA"** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

c. **"HRA Account"** means the account described in this Article.

d. **"HRA Account Administrator"** means the administrator that the Board of Trustees selects from time to time to administer the HRA Accounts.

e. **"HRA Participant"** means an Active Employee or a Qualified Beneficiary for whom the required contributions have been negotiated and paid. An HRA Participant may access his/her HRA account for reimbursement of eligible medical expenses incurred for/by the HRA Participant and his/her Spouse and Dependents.

f. **"Medical Care Expenses"** means expenses incurred by an HRA Participant for medical care and eligible for reimbursement pursuant to Code §213, and the rules and regulations thereunder, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees. Medical Care Expenses includes but is not limited to COBRA self-pay premiums. Medical Care Expenses does not include those expenses specifically excluded under Section 11 "HRA Exclusions." Reimbursements due for Medical Care Expenses incurred by the HRA Participant or the HRA Participant's Dependents shall be charged against the HRA Participant's Account.

g. **"Period of Coverage"** means the Plan Year, with the following exceptions:

   i) for an Active Employee who first became eligible to participate, it shall mean the portion of the Plan Year following the date participation commences; and

   ii) for an HRA Participant who terminates participation, it shall mean the portion of the Plan Year prior to the date participation terminates.

Section 4: Benefits and Funding.

a. **Benefits Offered**. When an Active Employee or Qualified Beneficiary becomes an HRA Participant, an account will be established for such HRA Participant to receive contributions actually made on his/her behalf for the purpose of providing benefits in the form of reimbursements for Medical Care Expenses and COBRA self-pay premiums, as described in Section 8 of this Article. In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

b. **Contributions**.

   i) Contributions. When the required contributions have been negotiated, the Employer will submit the contributions in the appropriate manner. If no contributions have been made on behalf of an individual, the individual will not become an HRA Participant.

   ii) HRA Participant Contributions. There are no HRA Participant contributions for benefits under the Plan.

c. **No Funding Under Cafeteria Plan**. Under no circumstances will the benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

Section 5: Health Reimbursement Benefits.

a. **Benefits**. The Plan will reimburse HRA Participants for Medical Care Expenses, except those expenses excluded under Section 11 "HRA Exclusions."

b. **Medical Care Expenses**. Under the HRA, an HRA Participant may receive reimbursement for eligible Medical Care Expenses incurred during a Period of Coverage, provided a claim for such benefits is submitted in the form prescribed by the Board of Trustees.

   i) Incurred. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before an HRA Participant first becomes covered by the Plan are not eligible. However, a Medical Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided that the HRA Participant was an HRA Participant in the Plan during both Periods of Coverage.

   ii) Cannot Be Reimbursed or Reimbursable from Another Source. Medical Care Expenses can only be reimbursed to the extent that the HRA Participant or other person incurring the expense is not reimbursed for the expense through the Plan, other insurance, or any other accident or health plan (e.g. another HRA or HSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Plan imposes copayment or deductible limitations), the HRA can reimburse the remaining portion of such expense if it otherwise meets the requirements herein.

c. **Establishment of Account**. The HRA Account Administrator will establish and maintain an HRA Account with respect to each HRA Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping of contributions and available reimbursement amounts.

i) Combined Accounts. Only one HRA Account will be established for the HRA Participant and his/her Spouse and/or Dependents. Reminder that both the HRA Participant and eligible dependents must each be enrolled in a group health plan that provides minimum value in order for this HRA plan to reimburse eligible expenses.

ii) Crediting of Accounts. An HRA Participant's account will be credited when they become eligible under the terms of this Article. The Plan Administrator shall calculate the amount to be credited to each HRA Participant's account pursuant to Section 4 "Benefits and Funding," and shall notify the HRA Participant as to the total available in the Account.

iii) Debiting of Accounts. An HRA Participant's account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

iv) Available Amount. The amount available for reimbursement of Medical Care Expenses is the amount credited to the HRA Participant's HRA Account as described above reduced by prior reimbursements debited as described above.

v) Carryover of Accounts. If any balance remains in the HRA Participant's account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the HRA Participant for Medical Care Expenses incurred during a subsequent Period of Coverage. There is no maximum or other limit on the amount available for carryover in the HRA Account.

Section 6: Retiree-Only HRA.

Upon retirement, and at the Participant's election, the HRA Account will become a Retiree-Only HRA Plan, exempt from various mandates of the Affordable Care Act, and the Participant may continue to use the HRA Account balance for Medical Care Expenses.

Section 7: Reimbursement Procedure.

a. **Claims Substantiation.** An HRA Participant who seeks benefits may apply for reimbursement by submitting an application in writing to the Administrative Office in such form as the Board of Trustees may prescribe, but no later than August 31 following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

1. the person or persons on whose behalf Medical Care Expenses have been incurred;
2. the nature and date of the Medical Care Expenses so incurred;
3. the amount of the requested reimbursement; and
4. a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrative Office may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $25.

b. **Timing of Reimbursements**. Within thirty (30) days after receipt by the HRA Account Administrator of a reimbursement claim from an HRA Participant, the HRA Account Administrator will reimburse the HRA Participant for appropriate Medical Care Expenses, or notify the HRA Participant that his/her claim has been denied.

1. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the HRA Account Administrator, including in cases where a reimbursement claim is incomplete.

2. The HRA Account Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the HRA Participant forty-five (45) days in which to complete an incomplete reimbursement claim.

c. Claims Denied. For reimbursement claims that are denied, see the appeals procedure in the Claim Filing and Appeals Information section in the National Roofers Union and Employers Joint Health and Welfare Plan.

Section 8: Reimbursements After Termination; COBRA Self-Pay Premiums.

a. When an HRA Participant ceases to be an HRA Participant hereunder, the HRA Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his/her participation terminates. Such HRA Participant (or the HRA Participant's Spouse, Dependent, or estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the HRA Participant (or the HRA Participant's Spouse, Dependent, or estate) files a claim within ninety (90) days following the close of the calendar year in which the Medical Care Expense arose.

b. A COBRA-eligible HRA Participant shall not be eligible for reimbursement after COBRA continuation coverage terminates.

Section 9: Administration, Termination, and Reinstatement.

a. **Inability to Locate Payee**. If the HRA Account Administrator is unable to make payment to any HRA Participant or other person to whom a payment is due under this Article because it cannot ascertain the identity or whereabouts of such HRA Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such HRA Participant or other person shall be subject to the provisions set forth in Section c "Account Maintenance".

b. **Effect of Mistake**. In the event of a mistake as to the eligibility or participation of an HRA Participant, or the allocations made to the account of any HRA Participant, or the amount of benefits paid or to be paid to an HRA Participant or other person, the HRA Account Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such HRA Participant or other person the credits to the HRA or distributions to which he/she is properly entitled under the Plan. Such action by the HRA Account Administrator may include withholding of any amounts due to the Plan from any future benefits.

c. **Account Maintenance**.

i) Inactive Accounts. Any HRA Account that remains inactive (no money coming in or money going out) for 12 consecutive months, will be suspended and the account will be frozen unless the HRA Participant submits satisfactory substantiation to the HRA Account Administrator of his/her intent to maintain the HRA Account. The HRA Account will be reinstated once contributions are made on behalf of the HRA Participant, or the HRA Participant elects to have the HRA become a Retiree-Only HRA.

ii) Leaving Covered Employment. Any HRA Account of an HRA Participant that 1) takes employment in any capacity or continues employment in any capacity with any employer in the roofing and waterproofing industry not obligated to contribute to the Fund, or 2) engages in any kind of commercial business activity in the roofing and waterproofing industry as a sole proprietor, partner, contractor or commission agent without being signatory to a labor agreement with any Roofers, Waterproofers and Allied Trades Local Union, or to a participation agreement with the Fund requiring contributions to the Fund will be forfeited and the HRA Account will be closed.

d. **Termination of Account**. An Active Employee or a Qualified Beneficiary will cease to be an HRA Participant upon the earlier of:

1. the date on which the HRA or this Plan is terminated;

2. the date the account is forfeited or suspended as outlined above; or

3. the date on which the HRA Participant's HRA Account reaches a zero balance.

e. **Divorce**. In the event of the HRA Participant's divorce, the HRA Account is not marital property and may not be used to reimburse medical expenses for an ex-Spouse otherwise ineligible under the Plan.

f. **Participation Following Death of an HRA Participant**. In the event of an HRA Participant's death, Spouses and tax-qualified Dependents may continue to submit eligible medical expenses to the HRA until the earlier of:

i) such time as the balance on the HRA Participant's HRA Account reaches zero; or

ii) the date the account is otherwise terminated as outlined above.

Section 10: No Guarantee of Tax Consequences.

a. Neither the HRA Account Administrator nor the Board of Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of an HRA Participant under this portion of the Plan will be excludable from the HRA Participant's gross income for federal, state, or local income tax purposes.

b. It shall be the obligation of each HRA Participant to determine whether each payment under this portion of the Plan is excludable from the HRA Participant's gross income for federal, state, and local income tax purposes, and to notify the HRA Account Administrator if the HRA Participant has any reason to believe that such payment is not so excludable.

Section 11: HRA Exclusions.

The following expenses are not Medical Care Expenses and are <u>not reimbursable</u> from the HRA Account even if they qualify as medical care under Internal Revenue Code §213:

a. Health insurance premiums for individual policies, whether purchased in the individual insurance market or on a state or federal Health Insurance Marketplace.

b. Health insurance premiums for any other group health plan (including a plan sponsored by a Contributing Employer).

c. Health insurance premiums for coverage that has been reimbursed under a spouse's plan (e.g. coverage subject to the "double-dip" prohibitions of Revenue Ruling 2002-3).

d. Long-term care services.

e. Any medicines or drugs, including over-the-counter medications (other than insulin) unless prescribed by a physician or licensed health care provider.

f. Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

g. The salary expense of a nurse to care for a healthy newborn at home.

h. Funeral and burial expenses.

i. Household and domestic help (even though recommended by a qualified physician due to an HRA Participant's inability to perform physical housework).

j. Massage therapy (unless it qualifies as a medical expense).

k. Home or automobile improvements (unless it qualifies as a medical expense because the improvements accommodate a disability).

l. Custodial care.

m. Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods (unless it is a residential school or program to treat behavioral, emotional and/or addictive conditions and the primary purpose of the program is medical care).

n. Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity (unless the expense would not have been incurred but for the disease).

o. Social activities, such as dance lessons, even though recommended by a physician for general health improvement (unless the activities qualify as medical expenses because they are recommended by a physician to treat a medical condition such as rehabilitation after surgery).

p. Bottled water.

q. Diaper service or diapers.

r. Cosmetics, toiletries, toothpaste, etc.

s. Vitamins and food supplements, even if prescribed by a physician (unless the vitamins or food supplements qualify as medical expenses because they are recommended by a physician for a specific medical condition).

t. Uniforms or special clothing, such as maternity clothing.

u. Automobile insurance premiums.

v. Transportation expenses of any sort, including transportation expenses to receive medical care (unless the expenses qualify as medical expenses because the expense is primarily for and essential to medical care).

w. Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

x. Any other item that does not constitute “medical care” as defined under Code §213.

ARTICLE XI – GENERAL PROVISIONS

Section 1. 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 paid. Such proof may include appropriate identification information (e.g. Social Security Number) for the Eligible Individuals who incurred the claim.

Section 2. Notice of Changes to Dependent Status Required

Eligible Employees are required to submit proof of any change in marital status to the Fund as soon as such proof is available. All marriage certificates and divorce decrees are required to be submitted to the Fund. In addition, Eligible Employees are required to notify the Fund in writing when a Dependent ceases to meet the Plan's definition of Dependent in Article I. This notice is required when:

a. An Eligible Employee's marriage is dissolved. Also, the Eligible Employee is required to submit the divorce decree to the Fund.

b. A Dependent disabled child over the Plan age limitations ceases to be disabled or ceases to be dependent upon the Eligible Employee or marries.

This notice must contain the name and the Social Security Number of the Eligible Employee and the name and address (if different from the Eligible Employee) of the Dependent whose status has changed. At the discretion of the Board of Trustees, an Eligible Employee who fails to comply with this Section may be required to repay to the Fund any benefits provided to persons not eligible, where their status would have been apparent from the notice required by this Section.

Section 3. Non-assignment

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered. A direction to pay a provider is not an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

Notwithstanding the foregoing, the Fund will honor any "**qualified medical child support order**" (QMCSO), 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.

Section 4. Claim Filing Deadline

Benefits will be paid by the Fund only if notice of claim is made within 90 days from the date on which expenses with respect to which claim is made were first incurred unless it shall be shown by the Eligible Employee not to have been reasonably possible to give notice within such time limit, but **in no event shall benefits be allowed if notice of claim is made beyond one year from the date on which expenses were incurred**.

Section 5. Facility of Payment

In the event the Board 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 Board with an address at which he can be located for payment, the Board 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 to the Eligible Employee, or to any other person or institution determined by the Board to be equitably entitled thereto. In the event of the death of the Eligible Employee before all amounts payable under Articles III, IV, V-A, V-B, VI and VII are paid, the Board may pay any such amount to any person or institution determined by the Board to be equitably entitled thereto. The remainder of such amount shall be paid to the Deceased Employee's

named Beneficiary. Any payment in accordance with this provision shall discharge the obligation of the Fund hereunder to the extent of such payment.

Section 6.

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 benefit field. Additionally, the Board may authorize payment for expenses not normally covered by the Plan in circumstances where payment of such expenses is to the advantage of the Plan and/or an Eligible Employee when compared to proposed expenses which are covered by the Plan.

Section 7.

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 a denial, written in a manner calculated to be understood by the establishment. A claimant aggrieved by such decision may request review. The Trustees shall establish and publish to Eligible Individuals the Trust Fund rules and procedures for review of denied claims. Such rules and procedures shall comply with federal law. No Eligible Dependent, Beneficiary or other person shall have any right or claim to benefits under the Plan or any right or claim to payments from the Fund other than as specified in these Benefit Rules, 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, or any Appeals Subcommittee of the Board of Trustees consisting of at least one Employer Trustee and one Employee Trustee, under and pursuant to the Fund and the Plan, and its decision of the dispute, right or claim shall be final and binding upon all parties thereto, subject only to such judicial review as may be in harmony with federal labor policy.

Section 8. Right to Examine

The Board, at its own expense, shall have the right and opportunity to examine the person of any Eligible Individual when and as often as it may reasonably require while any claim is pending. Failure of such Eligible Individual to allow such examination or to authorize the release of the results of such examination may cause the denial of the payment of benefits for the claim in question. Also, the Board shall have the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure, will be solely determined by the Board.

Section 9.

The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage by workers' compensation insurance laws or similar legislation.

Section 10.

The provisions of these Benefit Rules are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of these Benefit Rules and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

Section 11. Privacy.

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 HIPAA "Privacy Regulations"), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). 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.

A. Disclosure of PHI to the Trustees.

1. Disclosures by Plan. The Plan 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.
2. 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.
3. 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:
   a. The Plan's Payment activities,
   b. Those Health Care Operations designated in 45 C.F.R. Section 164.506(c)(4) with respect to the Plan, and
   c. 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.

   The Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)). 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.

B. 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.

C. Privacy Safeguards. The Trustees agree to:

1. Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;
2. 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;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;
4. 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;
5. 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;
6. Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;
7. 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;
8. 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;
9. 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;
10 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;
11. Ensure that adequate separation between the Plan and the Trustees is established, as described below; and
12. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. 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.

E. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. 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,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. 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
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Section 12. Termination for Cause

The Board of Trustees may end the eligibility of an Eligible Employee and/or any covered Dependents for cause thirty (30) days after written notice to the Eligible Employee of its finding that any of the following issues apply. Additionally, the Fund will offset future payable benefits to Eligible Individuals if the Fund suffers monetary loss from the following issues:

A. A fraudulent statement by an eligible individual or someone seeking coverage under the Plan, a material misrepresentation, or engaging in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact such as omitting any material information in any enrollment, claim or other form in order to obtain eligibility coverage, services or benefits under the Plan; or

B. Allowing anyone else to use any identification card that entitles an Eligible Employee or a covered Dependent to eligibility, coverage, services or benefits under the Plan; or

C. Altering any prescription furnished by a Physician.

If your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you have failed to pay your self-pay premium payment. In this instance, your coverage may be terminated retroactively to the date of the delinquent premium payment. In addition, your coverage may be suspended during the notice period.

ARTICLE XII – AMENDMENT AND TERMINATION

In order that the Fund may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Eligible Employees, the Board of Trustees expressly reserves the right in its sole discretion at any time and from time to time, but upon a non-discriminatory basis:

A. To terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already accrued.
B. To alter or postpone the method of payment of any benefit.
C. To amend or rescind any other provisions of these Benefit Rules.

Should the Plan terminate, any assets remaining after payment of Plan obligations will be dedicated to similar benefit purposes.

ARTICLE XIII – MAXIMUM LIABILITY OF THE FUND

Benefits described in this Plan are generally not insured by any contract of insurance and there is not liability upon the Board of Trustees or any individual or entity to provide payment over and beyond the amount in the Fund collected and available for such purpose.

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INFORMATION REQUIRED BY ERISA
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

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 National Roofers Union and Employers Joint Health and Welfare Fund is a welfare benefit plan providing medical expense, dental, vision, short-term disability and life and accidental death and dismemberment benefits to participants and beneficiaries. It is administered by a joint Board of Trustees consisting of three Union representatives and three Employer representatives.

The benefits described in this document are self-funded and administered by independent Claims Administrators whose names are listed on the Quick Reference Chart in the front of this document.

B. **The name and address of the Plan Administrator/Plan Sponsor is**:

Board of Trustees of the National Roofers Union and Employers Joint Health and Welfare Fund
C/o Wilson-McShane Corporation
3001 Metro Drive – Suite 500
Bloomington, MN 55425
Telephone: (952) 854-0795 or Toll-Free (800) 622-8780.

C. **Name and business addresses of the Trustees are**:

Union (Employee) Trustees	Management (Employer) Trustees
Kinsey Robinson – Employee Trustee United Union of Roofers, Waterproofers & Allied Workers 1660 "L" Street, N.W., Suite 800 Washington, DC 20036-5603	John Plescia - Employer Trustee Star Roofing 9201 N. Ninth Avenue Phoenix, AZ 85021
Jeff Eppenstein – Employee Trustee	Dennis Conway – Employer Trustee Commercial Roofers, Inc. 3865 W. Naples Drive Las Vegas, NV 89103
Mitch Terhaar – Employee Trustee	Lynn Price – Employer Trustee

D. **In addition to the Board of Trustees, the following person has been designated as agent for the service of legal process**:

Kenneth Kelley, Esq.
Kelley Law Group
3800 N. Central Ave, Suite 530
Phoenix, AZ 85012

E. **The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 51-0210922.**

The Plan number assigned by the Board of Trustees is 501.

F. **For purposes of maintaining the Fund's fiscal records, the year-end date is May 31**.

G. **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.

H. **Financial Information**:

Contribution Sources: All contributions to the Plan are made by Employers in accordance with collective bargaining agreements between Unions affiliated with the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO and participating employers. The collective bargaining agreements require contributions to the Plan at fixed rates per hour. 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 Willmington Trust Company and invested in a various investment vehicles with the assistance of Ulrich Investment Consultants. See the paragraph of entitled "Plan Documents" if you wish to obtain additional information concerning the Fund's investment of assets and checking accounts.

I. **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 Plan Document contained in this booklet.

Plan Regulations: All types of benefits provided by the Plan are set forth in the carious Schedules of Benefits contained in this booklet.

J. **Statement of ERISA Rights**:

Rights Of Plan Participants

As a Participant in the National Roofers Union and Employers Joint Health and Welfare 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 addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer, you 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 from 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 after exhaustion of available appeals. 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 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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

K. 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.

L. 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 will be provided in a manner determined in consultation with the attending Physician and the patient and is subject to the plan's annual copayments, annual deductibles, and coinsurance provisions.

M. **Claim Procedures**

The procedures to follow for filing a claim for benefits are set forth in this booklet. All claims for benefits must be submitted on claim forms made available by the Administrative Office or other provider. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

N. **Review and Appeals Procedures**

The procedures to follow for appealing an adverse claim determination are also set forth in this booklet.

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 800-622-8780.

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 at 3001 Metro Drive – Suite 500, Bloomington, MN 55425. The office hours are from 8:00 am to 5:00 pm Central time, Monday through Friday. You may also call the Administrative Office at (800-622-8780).

Q. **Privacy**

Effective April 14, 2004, 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 National Roofers Union and Employers Joint Health and Welfare Fund (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 your employer or your union in its role as an employer or bargaining unit, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), life insurance, drug testing, etc.

A description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which is available from the Administrative Office. See also Article XI for more information.

R. **Authority**

Nothing in this booklet is meant to interpret or change in any way the provisions expressed in the Benefit Rules of the Health and Welfare Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.

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