# Plan Endorsement #22-SP

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|---|---|---|---|
| GROUP # | A16103 | | |
| EFFECTIVE DATE | January 1, 2022 | | |
| EMPLOYER ID# | 35-6034831 | PLAN # | 501 |
| NAME OF PLAN | International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund Employee Benefits Plan | | |
| PLAN DESCRIPTION | PPO PLAN | | |

The following wording is hereby added to the Plan:

The Board of Trustees of the International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund, of Lansing, MI hereby amends and restates its existing plan for payment of certain expenses for the benefit of eligible employees of participating employers known as the International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund Employee Benefits Plan. The attached document serves as the summary plan description, plan description and plan document for the Plan.

The Board of Trustees of the International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund has caused this Plan amended and restated Plan to take effect as of 12:01 A.M. Eastern Time on January 1, 2022 at Lansing, MI.

All other provisions of the Plan remain unchanged.

APPROVED AND ATTESTED:

BY _____ TITLE Chairman

DATE 2/10/2022

APPROVED AND ATTESTED:

BY _____ TITLE Secretary

DATE 2/10/2022

# THE BOARD OF TRUSTEES OF THE INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL #1392 HEALTH AND WELFARE FUND

6525 Centurion Drive
Lansing, MI 48917-9275
Phone: (517) 321-7502

# PPO PLAN

***This booklet describes the Medical benefits for Eligible Employees of contributing Employers in the International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund Employee Benefits Plan.***

Information Applicable to Plan 501

Employer Identification Number
35-6034831

**The Benefits In This Booklet Are Effective**
**January 1, 2022**

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# KEY INFORMATION

**EMPLOYER/COMPANY/PLAN ADMINISTRATOR/PLAN SPONSOR CONTACT INFORMATION:**
Board of Trustees of the International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund
6525 Centurion Drive
Lansing, MI 48917-9275
Phone: (517) 321-7502

Under collective bargaining agreements between International Brotherhood of Electrical Workers Local Union No. 1392 (the "Union") and various employers ("contributing Employers"), the Board of Trustees maintains an employee welfare benefit plan known as the International Brotherhood of Electrical Workers Local # 1392 Health and Welfare Fund Employee Benefits Plan (the "Plan"). You may obtain a list of each contributing Employer required to contribute to the Plan under a collective bargaining agreement with the union by written request to the Plan Administrator. You may also ask the Plan Administrator whether a particular employer is a contributing Employer, and if so, receive the employer's address.

The Plan is administered and maintained by the Board of Trustees. The Board of Trustees is the Plan Sponsor. The Board of Trustees has the discretion to delegate its fiduciary and other duties as it sees fit. The Trustees have selected a professional employee benefits firm as the Claims Processor of the Plan and a professional multiemployer plan administration firm as the administrative manager of the Plan.

**PLAN SPONSOR IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):**
35-6034831

**PLAN NAME:**
International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund Employee Benefits Plan.

**PLAN CONTACT INFORMATION:**
Board of Trustees of the International Brotherhood of Electrical Workers Local #1392 Health and Welfare Fund
6525 Centurion Drive
Lansing, MI 48917-9275
Phone: (517) 321-7502

**PLAN NUMBER:**
501

**STOP LOSS COVERAGE:**
The Plan Sponsor has purchased specific and aggregate stop-loss reinsurance coverage.

**GROUP NUMBER:**
A16103

**SPD EFFECTIVE DATE:**
January 1, 2022

**PLAN YEAR:**
The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends each September 30th.

**TYPE OF PLAN:**
The Plan provides medical and prescription drug benefits, life and AD&D benefits, and weekly loss of time benefits for short term disability. This type of plan is classified as an "employee welfare benefit plan" under federal law.

**NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:**
Allied Benefit Systems, LLC
P. O. Box 909786-60690
Chicago, IL 60690
Phone: (312) 906-8080 or (800) 288-2078 (outside IL)

**NAME, ADDRESS AND TELEPHONE NUMBER OF THE ADMINISTRATIVE MANAGER:**
TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275
Phone: (517) 321-7502

**BOARD OF TRUSTEES**

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**KW Services**
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South Bend, Indiana 46628

**Pam Dosmann**
Northern Electric Company
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South Bend, Indiana 46617

**Richard Siri**
Enyart Electric Motor Repair
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56436 Strasser Lane
South Bend, Indiana 46619

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KW Services
3801 Voorde drive, Suite B
South Bend, Indiana 46628

**Charles Harper**
Northern Electric Company
116 North Hill Street
South Bend, Indiana 46617

**PRIVACY OFFICERS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA):**

The following persons under contracts with the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

- Employees of the Claims Processor
- Employees of the Administrative Manager

## ERISA GRANDFATHERED:

**THIS PLAN IS A GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT:**

This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**ELIGIBILITY for active Employees:**

Active Employees who perform work under the collective bargaining agreement. An Employee is eligible for coverage if he has at least 475 hours of service per quarter or 1,900 hours of service in the current period and the three previous contribution periods, made proper application, and paid any applicable assessments to the fund (which are presently $20.00 per week for single coverage or $40.00 per week for family coverage).

The Employee may continue eligibility by contributing to the Plan the difference between the amount contributed in the current period and 475 hours times the rate per hour required in the collective bargaining agreement plus any applicable assessments for each qualified period.

Eligibility is based on contribution quarters (work quarters) and benefit quarters (quarters in which You are eligible for benefits) as follows:

| Contribution Quarters<br>work performed during… | Benefit Quarters<br>determines eligibility in… |
|---|---|
| September, October and November | January, February and March |
| December, January and February | April, May and June |
| March, April and May | July, August and September |
| June, July and August | October, November and December |

**INITIAL ELIGIBILITY**

A newly hired Employee will be eligible for coverage under the Plan on the first day of the fourth month after his/her hire date. Withholding of assessments payments from paychecks begins two months prior to date of eligibility. With the initial eligibility rules, it will not be necessary to have 475 hours contributed on Your behalf.

EXAMPLE:

| Hire date | Eligibility date | Assessment Begins |
|---|---|---|
| January 2nd | May 1st | March 1st |
| May 30th | September 1st | July 1st |

On Your effective date of coverage, coverage will also start for any of Your family members who meet the Plan's definition of a dependent. If You acquire a new dependent after Your effective date of coverage, and while You are still eligible for benefits, that person's effective date of coverage will be the date the person became Your dependent.

## CONTINUATION OF ELIGIBILITY

**ELIGIBILITY DUE TO EMPLOYER CONTRIBUTIONS:**

After becoming initially eligible, You will continue to be eligible in each succeeding benefit quarter as long as You are working for a contributing employer who makes contributions to the fund on Your behalf and you have 475 hours of service in the corresponding contribution quarter **and** you have also paid the applicable assessments.

Hours of service will be credited for purposes of determining eligibility in the same way as they are credited under the International Brotherhood of Electrical Workers Local Union No. 1392 Pension Plan.

**ELIGIBILITY DURING DISABILITY:**

If You become permanently and totally disabled, or totally (but not permanently) disabled and unable to work in the trade or perform any other gainful employment, Your eligibility will be maintained according to the following rules:

1. You must be completely prevented from engaging in covered employment as a result of accidental bodily injury or sickness. Disability credit will not be granted if You are gainfully employed in any capacity.

2. You must be entitled to weekly loss of time benefits as a result of Your injury or sickness.

3. You cannot be maintaining Your eligibility by making COBRA self-payments.

4. You must provide the fund office with all required proofs of total disability and entitlement to weekly loss of time benefits or workers' compensation disability benefits.

5. The maximum period your eligibility will be extended during any one period of disability will be 26 consecutive weeks.

6. If You qualify for eligibility protection during disability in accordance with these rules, You will be credited with 38 disability hours for each week You are disabled to help You maintain your eligibility. The disability hours credited to You will be considered regular credited hours and will apply toward maintaining your eligibility for benefits the same as though You had worked the hours.

7. The Trustees retain the right to have You medically examined by a doctor of their own choice at the Plan's expense to determine whether a disability qualifies under this provision.

8. If You elect COBRA Coverage because You cannot return to work and reestablish eligibility, any eligibility extension you receive under these disability provisions will apply toward Your 18-month COBRA period. For example, if You are granted 3 months of eligibility under these disability rules, You can then make COBRA self-payments for an additional 15 months.

**SELF-PAYMENT OF CONTRIBUTIONS ("REGULAR SELF-PAYMENTS"):**
*The regular self-payment described in this section are NOT the same as COBRA self-payments*. Regular self-payments are for contribution quarters (You pay for eligibility in a later quarter); while COBRA self-payments are for the same month You are eligible. Also, the amounts of the self-payments and the due dates are different.

If you establish initial eligibility, but then have a period of unemployment that endangers Your continuing eligibility, You can make a regular self-payment to continue Your coverage (and coverage for Your Dependents).

To be eligible to make regular self-payments, You must be available for work in covered employment in the industry with an employer who contributes to this fund.

The amount of the regular self-payment required will be equal to 475 hours times the hourly rate in effect for contributing employers. The 475 hours will be reduced by Your hours worked in the most recent contribution quarter, if any.

| |
|---|
| Regular self-payments must be mailed to the fund office and postmarked no later than **the due date specified in the notice** for which the payment is being made.<br><br>A notice that a regular self-payment is due will be sent by mail to the last known valid address on file at the fund office, so it is important that any address changes are reported immediately. |

Eligibility by means of regular self-payments can be continued for a maximum of four (4) successive benefit quarters.

When You are eligible due to a regular self-payment, You and Your covered Dependents will be entitled to the same benefits, and subject to the same limitations and provisions, as Employees who are eligible due to active employment.

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**

- **Eligible Leave**
  An Employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.

- **Contributions**
  During this leave, the contributing Employer will continue to pay the same portion of the Employee's contribution for the Plan. The Employee will be responsible to continue payment for eligible Dependent's coverage and any remaining Employee contributions. If the covered Employee fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

- **Reinstatement**
  If coverage under the Plan was terminated during an approved FMLA leave, and the Employee returns to active work with a contributing Employer immediately upon completion of that leave, Plan coverage will be reinstated on the date the Employee returns to active work as if coverage had not terminated, provided the Employee makes any necessary contributions and enrolls for coverage within thirty (30) of his return to active work.

- **Repayment Requirement**
  The Plan Administrator may require Employees who fail to return from a leave under FMLA to repay any contributions paid by the contributing Employer on the Employee's behalf during an unpaid leave. This repayment will be required only if the Employee's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the Employee's control.

**ELIGIBILITY for Retirees:**

- Retirees:
  - performed work under the collective bargaining agreement;
  - was employed by a contributing Employer immediately before retirement;
  - is eligible to receive a pension benefit from the International Brotherhood of Electrical Workers Local 1392 Pension Plan, and
  - has otherwise met the Plan's eligibility requirements to continue coverage under the Plan as a retiree.

As used in this document, the term “Employee” shall include retirees covered under the Plan. Retired employees may continue coverage by paying the applicable contribution for Employee and/or Dependent coverage. While the Board of Trustees expects retiree coverage to continue, the Board of Trustees reserves the right to modify or discontinue retiree coverage or any other provision of the Plan at any time. Note: retirees over age 65 are not eligible for the prescription drug plan benefits.

- Dependents Including:

  - Dependent Children: Children are eligible for coverage as Dependents from birth to the last day of the month they attain age 26 and all of the following are considered eligible children under the Plan: natural children, stepchildren, foster children, adopted children, children placed for adoption and children under legal guardianship. An eligible child shall also include any other child of an Employee or the Employee's spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child is not residing in the Employee's household. Such child shall be referred to as an alternate recipient. Alternate recipients are eligible for coverage only if the Employee is also covered under this Plan. An application for enrollment must be submitted to the plan administrator for coverage under this Plan.

  - Legal Spouses are eligible for coverage under this Plan. This Plan defines "marriage" as both 1) a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage, and 2) a legal union between two persons of the same sex, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement.

  - Spouses of deceased retired Employees are eligible for coverage under this Plan under the COBRA provisions.

  - Domestic Partners: This Plan does not cover Domestic Partners.

**WORKING SPOUSE COVERAGE PROVISION:**

No surcharge will be levied if the spouse of an eligible Employee is eligible for coverage under a health plan of the spouse's employer and chooses coverage from this Plan instead.

**ENROLLMENT– COVERAGE EFFECTIVE DATE:**

- **Enrollment Waiting Period:**

  All eligible Employees shall be eligible for coverage on the first day of the fourth month of hire. See Initial Eligibility Requirements above.

- **Open Enrollment Period:**

  The Plan designates the month of December in each calendar year as an Open Enrollment Period. Unless the Employee or the dependent qualifies for a Special Enrollment Period, it is only during this Open Enrollment Period that an eligible Employee who did not enroll after becoming first eligible may enroll in the Plan. Coverage starts on the following January 1 if the Employee or dependent enrolls in the Plan during the December Open Enrollment Period.

  Except for status changes, the Open Enrollment Period is the only time an Employee may change benefit options or change enrollment.

Status changes include the following:

1. Change in family status as a result of one of the following events:
   a. Change in Employee's legal marital status;
   b. Change in Employee's number of Dependents;
   c. Termination or commencement of employment by Employee, spouse, or Dependent;
   d. Change in work schedule;
   e. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements; or
   f. Change in worksite or residence of Employee, spouse, or dependent.
2. Change in the cost of coverage under the Plan;
3. Cessation of required contributions;
4. Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993;
5. Significant change in the health coverage of Employee or spouse attributable to spouse's employment;
6. Special Enrollment Period mandated by the Health Insurance Portability And Accountability Act of 1996;
7. A court order, judgment, or decree;
8. Entitlement to Medicare or Medicaid; or
9. A COBRA qualifying event.

- **Switch Enrollment Period:**
  This Plan does not have a switch enrollment period.

- **Late Enrollment Period*:***
  An enrollment which takes place other than during the first period during which an individual was eligible for coverage, or other than during a period of Special Enrollment or Open Enrollment. This Plan does not have a late enrollment period.

**TERMINATION OF COVERAGE:**

- **Employee:** The coverage of any Employee covered under this Plan will terminate on the earliest of the following**:**
  - The last day of the benefit quarter preceding the benefit quarter for which the Employee failed to meet the requirements for continuing eligibility, including a failure to make any self-payment or assessments in a timely manner.
  - The last day of the month which the Employee ceases to meet the eligibility requirements of the Plan;
  - The date the Employee becomes a full-time active member of the armed forces of any country;
  - The date the Employee ceases to make any required contributions; or
  - The date of termination of the Plan by the Plan Sponsor without offering another group health plan.

- **Dependents:** The coverage of any Dependent covered under this Plan will terminate on the earliest of the following:
  - The last day of the month such individual ceases to meet the definition of Dependent, as listed in the Key Information section; or

- The date the Employee's coverage terminates under the Plan.
- The date the Employee stops making required contributions on the Dependent's behalf;
- The date the Plan discontinues coverage for all Dependents; or
- The date the Dependent becomes a full-time active member of the armed forces of any country.

In the event of the Employee's death dependent coverage will terminate on the last day of the Benefit Quarter for which he had earned eligibility due to employer contributions, disability hours or Regular self-payments. (Surviving dependents cannot make Regular self-payments after the Employee's death, but they may be entitled to make COBRA self-payments in accordance with the COBRA Continuation Coverage.

# PRE-CERTIFICATION PROGRAM

Your Plan also includes a **Pre-Certification Program**. The toll-free number you must use for pre-certification is shown on your member ID card. **Failure to follow the guidelines listed below will subject your benefits to a Penalty for Non-Compliance as discussed in this section and referenced in the Schedule of Covered Services and Provisions.**

**The following service requires pre-certification:**

1. Inpatient Hospital admissions.
2. Home Health Care Services.

**If your Physician recommends any service listed above, please follow these steps:**

1. Notify your Physician that you participate in a Pre-Certification Program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.

2. You or your Physician must call the number shown on your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission or any of the services listed above.

3. If you have an emergency admission, pre-certification is required within 48 hours or the next business day following admission.

The following information will be needed to pre-certify:

| **Regarding Patient:** | **Regarding Employee:** |
|---|---|
| Name | Name |
| Address | Address |
| Telephone # | Telephone # |
| Date of Birth | Date of Birth |
| Relationship to Employee | Gender |
| Physician's Name | Social Security Number |
| Physician's Phone Number | Name of Employer |
| Hospital/Address | Name of Claims Processor:<br>*Allied Benefit Systems, LLC* |

4. A nurse may call your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.

5. When you or your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:

   a. The facility can verify that pre-certification has been done and can track expected length of stay.

   b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

**Note**: Pre-Certification assists in determining medical necessity and the best place for treatment. This service, however, does not guarantee payment, which is subject to eligibility and coverage at the time services are rendered.

## PENALTY FOR NON-COMPLIANCE:

Unless prohibited under federal law, the non-compliance penalty specified in the Schedule of Covered Services and Provisions will apply under one or more of the following circumstances: a) a pre-certification call is not made according to the instructions within this section; b) an Inpatient stay exceeds the amount of days pre-certified; or c) a patient is admitted as an Inpatient when treatment could have been performed on an Outpatient basis.

This penalty will be applied in addition to any applicable Deductible and will not be applied to any Out-of-Pocket Maximum as specified in the "Schedule of Covered Services and Provisions". The penalty will be applied to Covered Services that were incurred during the days that were not pre-certified.

# PPO SCHEDULE OF COVERED SERVICES AND PROVISIONS

## I. MEDICAL CARE BENEFITS:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Calendar Year Deductible** *(taken before benefits are payable unless waived)*<br>*This is an embedded Deductible, meaning each covered family member only needs to satisfy his or her individual Deductible, not the entire Family Deductible, prior to receiving plan benefits. The balance of the Family Deductible can be satisfied by one member or a combination of remaining family members.* | $600 per person<br>$1,200 per family | $1,000 per person<br>$2,000 per family |
| **Separate Inpatient Hospital Deductible per occurrence** | N/A | $300 |
| **Deductible Carry-Over** | N/A | |
| **Common Accident Provision** | If two or more covered members of a family are injured in the same accident and, as a result of that accident, incur *covered expenses*, only one individual deductible amount will be deducted from the total covered expenses of all covered family members related to the accident for the remainder of the calendar year. | |
| **Out-of-Pocket Maximum per Calendar Year** *(*co-insurance levels count towards the Out-of-Pocket Maximum) ***Excludes Deductible and medical co-pays.***<br>*After amount is reached, 100% level of benefits applies for that Calendar Year.* The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum:<br>• "Non-compliance penalty" (for failure to abide by pre-certification requirements).<br>• Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit.<br>*This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits paid at 100%. The balance of the family Out-of-Pocket Maximum can be satisfied by one member or a combination of remaining family members.* | $1,500 per person<br>$3,000 per family | $3,000 per person<br>$6,000 per family |
| **Calendar Year Benefit Maximum** | Unlimited | |
| **Precertification Penalty for Non-Compliance: Certain benefits are subject to a $200 penalty** per occurrence ***(in addition to Deductible)*** for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section for additional information. | Allied Care<br>1-800-892-1893 | |
| **Claims Filing Limit** | All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred. | |
| **Coordination of Benefits** | If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges. | |
| **Deductible and In-Network and Out-of-Network Out of Pocket Maximums are "aggregated," such that covered services applied to one also apply to the other.** | | |

**II. PRESCRIPTION DRUG BENEFIT:** Note: Retirees over age 65 are not eligible for the prescription drug plan benefits.

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| *Your Prescription Drug Benefit is administered by Caremark. For prescription drug questions please call 1-866-885-4944 or visit www.caremark.com.* | | |
| If doctor requests brand only when a generic is available, the member will be charged the generic co-pay plus the cost difference between the brand and generic medication. | | |
| **Generic - Prescription Drug Card Benefit** *(up to 34-day supply per prescription through participating pharmacies) and* **Mail-Order Drug Benefit** (*up to 91-day supply per prescription through mail order)* | 100%<br>Deductible Waived | |
| **Brand Name - Prescription Drug Card Benefit** *(up to 34-day supply per prescription through participating pharmacies) and* **Mail-Order Drug Benefit** (*up to 91-day supply per prescription through mail order)* | 80% subject to the In-Network Deductible and Out-of-Pocket Maximum | |
| **Mail-Order/Extended Retail Pharmacy Drug Benefit** | Optional | |
| **Oral Specialty Drug Pharmacy Benefit**<br>*Please refer to Prescription Drug Benefit section for further details.* | 80% subject to the In-Network Deductible and Out-of-Pocket Maximum | |

## III. PREVENTIVE CARE SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Preventive Care Services** - (*must be billed with a routine diagnosis).*<br><br>*Covered expenses* shall include the following routine services and supplies which are not required due to *illness* or *injury*: physical check-up; routine well baby check-up, routine pediatric examination, immunizations, laboratory and other tests given in connection with routine examinations, gynecological examination, one (1) Papanicolaou test (Pap Smear) per calendar year; prostate examination and prostate specific antigen test; one (1) mammogram (including 3D) per calendar year. Benefits do not include routine colorectal screenings such as sigmoidoscopy or colonoscopy. | First $100 in Covered Expenses, per person per Calendar Year, shall be payable at 100%<br>Deductible waived.<br>Thereafter, a $20 co-pay shall apply, then paid at 50% subject to applicable In-Network or Out-of-Network deductible and Out-of-Pocket maximum | |

## IV. PHYSICIAN SERVICES:

| COVERED SERVICES and PROVISIONS<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), covered services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Virtual Physician charges** | Paid same as any other service according to type of service and provider. | |
| **Physician Office Visits -** Includes all services performed in the office.<br>*Does not include surgery, allergy injections. Please see below and Section V for additional benefit coverage information.* | $25 co-pay, then paid at 100% Deductible waived. | 60% |
| **Specialist Office Visits –** Includes all services performed in the office.<br>*Unless listed separately within this schedule.*<br>*Does not include surgery, allergy injections. Please see below and Section V for additional benefit coverage information.*<br>*Allied considers the following doctors as primary care physicians, all others would be specialists:*<br>• *General Practice.*<br>• *Family Practice.*<br>• *OB/Gyn.*<br>• *Internal Medicine.*<br>• *Osteopaths.*<br>• *Pediatricians.*<br>• *Physician Assistants*<br>• *Nurse Practitioners*<br>• *All covered Mental Health providers* | $40 co-pay, then paid at 100% Deductible waived. | 60% |
| **Urgent Care** - Includes all services performed in the Urgent Care, including surgeries.<br>*Does not include allergy injections or labs and X-rays. Please see below and Section V for additional benefit coverage information.* | $25 co-pay, then paid at 100% Deductible waived. | 60% |
| **Second Surgical Opinion** | 80% | 60% |
| **Surgery Incurred at a Physician's Office**<br>*Does not include labs and X-rays. Please see Section V for additional benefit coverage information.* | 80% | 60% |
| **Emergency Room Physician Care** | Please refer to Emergency Room Services benefit in Section VI. | |
| **Physical, Speech, Occupational, Vision (orthoptics), Respiratory, and Radiation Therapy**<br>*Limited to a combined maximum of 60 Visits for office and Outpatient facility services, per Covered Person per Calendar Year. However, this Calendar Year visit maximum does not apply to covered therapy services for autism.* | 80% | 60% |
| **All Care Rendered by a Chiropractor**<br>*All services provided by a chiropractor are limited to $1,000 per Covered Person per Calendar Year.* | 80% | 60% |
| **Diabetes Self-Management Education Program**<br>*Limited to $500.00 Maximum per Covered Person per Calendar Year.* | 80% | 60% |
| **Podiatry Services** | $25 co-pay, then paid at 100% Deductible waived. | 60% |
| **Anesthesia and its Administration** *(Inpatient/Outpatient)* | 80% | 60% |
| **Other Physician Services**<br>*Does not include labs and X-rays; please see Section V for additional benefit coverage information.* | 80% | 60% |
| **If a referral is made to a non-network Physician or non-network specialist/facility by a network Physician** (due to Medically Necessary services not being available In-Network). | N/A | Paid same as In Network. |

## IV. PHYSICIAN SERVICES:

| COVERED SERVICES and PROVISIONS<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), covered services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Non-Network Physician Services Received at a Network Hospital**<br>*If services are performed by a 1) non-network anesthesiologist or 2) a non-network specialist, such as a radiologist or pathologist, who is requested or required by that network Hospital, the charges will be covered as if rendered by a network Physician.* | N/A | Paid same as In-Network. |

## V. OUTPATIENT/INDEPENDENT LABORATORY/RADIOLOGY/PATHOLOGY SERVICES, INCLUDING ADMINISTRATION AND MRI, PET, AND CT SCANS:

| COVERED SERVICES and PROVISIONS<br>*Note: Payment of charges billed on a Form CMS-1500 exceeding $50,000 will be limited to the Medicare fee schedule.* | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient/Independent Laboratory Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services**<br>*Does not include above services performed in conjunction with the following:*<br>• *Chiropractic Care.*<br>• *Emergency Room Services.*<br>• *Pre-admission testing*<br>*Does not include MRI, PET or CT scans.* | 100%<br>Deductible Waived | |
| **Outpatient/Office/Independent Laboratory Imaging Services (MRI, PET, and CT scans)** | 80% | 60% |

## VI. FACILITY SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Emergency Room Services- Emergency Care** | $100 co-pay, then paid at 100%<br>Co-pay waived if admitted to Hospital directly from Emergency Room. | $100 co-pay, then paid at 100%<br>Co-pay waived if admitted to Hospital directly from Emergency Room. |
| **Emergency Room Services- Non-Emergency Care** | 80% | 60% |
| **Inpatient Hospital Services**<br>*Coverage is limited to:*<br>• *Room and board not to exceed the semi-private room rate.*<br>• *Necessary services and supplies including an intensive care unit and a cardiac care unit.*<br>• *If admitted through the Hospital Emergency Room, this benefit will be covered at the In-Network level.*<br>*Note: Room and board subject to the payment of semi-private room rate, unless the Hospital only has private rooms.* | 80% | 60% after Separate $300 per occurrence deductible and subject to overall Calendar Year deductible |

## VI. FACILITY SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures** | 80% | 60% |
| **Outpatient Hospital Facility Charges** | 80% | 60% |
| **Pre-admission testing** | 80% | 60% |
| **Renal Dialysis -** *Golden Triangle Specialty Network, LLC Renal Network Providers*<br>***Note**: Pre-Certification is required.* | 80% | Paid Same as In-Network |
| **Renal Dialysis - all other providers** | 80% | 60% |
| **Urgent Care Services facility fees** | 80% | 60% |

## VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **BEHAVIOR HEALTH BENEFIT (Mental/Nervous/Substance Use Disorders)** | | |
| **Treatment for Mental/Nervous and Substance Use Disorders**<br>*Please see the definitions of Physician and Hospital for further detail.*<br>*Note: Inpatient mental/nervous and substance use disorder services must be pre-authorized through Allied Care Solutions in order to avoid $200 penalty per occurrence.* | Paid same as any other service according to type of service, provider and place of service. | |

## VIII. OTHER COVERED SERVICES:

| **COVERED SERVICES and PROVISIONS**<br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered services and Provisions.**<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), covered services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Other Covered Services/Items** | 80%<br>Unless included in a separate category. | 60%<br>Unless included in a separate category. |
| **Abortion** | 80% | 60% |
| **Acupuncture** | Not Covered | |
| **Artificial Limbs, Eyes and Larynx** | 80% | 60% |
| **Assisted Reproduction**<br>*All services provided are limited to $10,000 per Covered Person per Lifetime.*<br>*Benefit applies if the Covered Person has been unable to attain or sustain a successful pregnancy through Reasonable, less costly medically appropriate infertility treatments.*<br>*Limited to Covered Individuals who are at least 26 years old.*<br>• *Limited to 4 or less attempts at artificial reproduction per person per Lifetime.*<br>o *Limited to the Covered Person who has not undergone more than 4 attempts at assisted reproduction. If a live birth follows 1 of the attempts of assisted reproduction, then 2 additional attempts will be permitted.*<br>o *Limited to procedures performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in-vitro fertilization clinics, and to the American Fertility Society minimal standards of in-vitro fertilization programs.*<br>o *Limited to services or supplies of assisted reproduction including in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer.*<br>*Benefit does not apply to services rendered to a surrogate mother for purposes of child birth.*<br>*Benefit does not apply for expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures which use a cryo-preserved substance.* | 80% | 60% |
| **Autism Spectrum Disorders**<br>Such diagnosis entails 1 or more tests, evaluations, or assessments to diagnose whether an individual has an autism spectrum disorder. Such tests, evaluations, or assessments must be prescribed, performed, or ordered by a physician licensed to practice medicine in all its branches, or a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders. However, some of the services may be delivered by certified or licensed professionals who are not physicians (including but not limited to speech therapists, physical therapists, and occupational therapists).<br>For those diagnosed with this disorder, the following treatments are covered:<br>• Psychiatric and Psychological care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist or psychologist;<br>• <u>*For Dependent Children only*</u>: Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.<br>Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified. | 80%<br>Except as may be covered differently for specific services listed elsewhere in the schedule. | 60%<br>Except as may be covered differently for specific services listed elsewhere in the schedule. |

## VIII. OTHER COVERED SERVICES:

| **COVERED SERVICES and PROVISIONS**<br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered services and Provisions.**<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), covered services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Birthing Centers Includes Services of a midwife** *acting within the scope of his license or registration are a covered expense provided that the state in which such service is performed has legally recognized midwife delivery.* | 80% | 60% |
| **Casts, Splints, Trusses, and Braces** | 80% | 60% |
| **Contact Lenses or Glasses Following Cataract Surgery**<br>*Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.* | 80% | 60% |
| **Dental Treatment** *when rendered by a Physician, dentist or oral surgeon for* ***a*** **fractured jaw** *or for* **accidental Injuries to natural teeth** *after the accident (replacement or repair of a denture not covered); oral surgery such as closed or open reduction of fractures or dislocations of the jaw, removal of cysts and tumors of the mouth and removal of soft tissue impacted teeth,* **services** *and* **supplies** *furnished by a Hospital during Medically Necessary confinement in connection with* dental treatment. *Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the covered person has a concurrent hazardous medical condition that prohibits performing the treatment safely in an office setting* | 80% | 60% |
| **Durable Medical Equipment**<br>*Includes:*<br>• *Cost to purchase or rent up to purchase price.*<br>• *Insulin pump, glucose monitors and other diabetic supplies when Medically Necessary and not covered though Your prescription drug vendor.*<br>• *Equipment for administration of oxygen.*<br>• *Equipment repair or replacement.* | 80% | 60% |
| **Family Planning - Men's Permanent Procedures**<br>*Includes:*<br>• *Voluntary sterilization.*<br>o *Male vasectomy.* | 80% | 60% |
| **Foot Orthotics** | Not Covered | |

## VIII. OTHER COVERED SERVICES:

| **COVERED SERVICES and PROVISIONS**<br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered services and Provisions.**<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), covered services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Gender Affirming Surgery (including any associated labs and x-rays)**<br>*The Plan considers gender affirming surgery medically necessary when all of the following criteria are met:*<br>*1. Requirements for mastectomy for female-to-male patients:*<br>*a. Single letter of referral from a qualified mental health professional; and*<br>*b. Persistent, well-documented gender dysphoria; and*<br>*c. Capacity to make a fully informed decision and to consent for treatment; and*<br>*d. Age of majority (18 years of age or older); and*<br>*e. If significant medical or mental health concerns are present, they must be reasonably well controlled.*<br>*Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.*<br>*2. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):*<br>*a. Two referral letters from qualified mental health professionals, one in a purely evaluative role; and*<br>*b. Persistent, well-documented gender dysphoria; and*<br>*c. Capacity to make a fully informed decision and to consent for treatment; and*<br>*d. Age of majority (18 years or older); and*<br>*e. If significant medical or mental health concerns are present, they must be reasonably well controlled; and*<br>*f. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)*<br>*3. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female)*<br>*a. Two referral letters from qualified mental health professionals, one in a purely evaluative role; and*<br>*b. Persistent, well-documented gender dysphoria; and*<br>*c. Capacity to make a fully informed decision and to consent for treatment; and*<br>*d. Age of majority (age 18 years and older); and*<br>*e. If significant medical or mental health concerns are present, they must be reasonably well controlled; and*<br>*f. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); and*<br>*g. Twelve months of living in a gender role that is congruent with their gender identity (real life experience).* | 80% | 60% |
| **Home Health Care**<br>*Limited to one visit per provider per day. Each 4 hours of service by a home health aide will be considered 1 home health visit.* | 80% | 60% |

## VIII. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered services and Provisions.**<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), covered services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Hospice Care**<br>*Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.* | 80% | 60% |
| **Infertility Testing**<br>*Limited to Covered services necessary to diagnose this condition, but not any charges in connection with the promotion of conception.*<br>*Infertility means the inability to conceive a child, or the inability to sustain a successful pregnancy.* | Paid same as any other service according to type of service, provider and place of service. | |
| **Infusion therapy and injections** | 80% | 60% |
| **Mastectomy Related Treatment**<br>*Includes charges in accordance with the provisions detailed under the definition of "Reconstructive Breast Surgery."* | 80% | 60% |
| **Obesity Surgery**<br>Benefit does not apply unless Covered Person:<br>• Has attempted weight loss in the past without successful long-term weight reduction; and<br>• Meets either a physician-supervised nutrition and exercise program or a multidisciplinary surgical preparatory regimen.<br>Benefit does not apply unless the *Adult* Covered Person:<br>• Has a body mass index (BMI) exceeding 40; *or*<br>• Has a BMI greater than 35 in conjunction with any of the following severe co-morbidities:<br>o Clinically significant obstructive sleep apnea (i.e., patient meets the criteria for treatment of obstructive sleep apnea); or<br>o Coronary heart disease; *or*<br>o Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management); *or*<br>o Type 2 diabetes mellitus. | 80% | 60% |
| **Organ or Tissue Transplant Procedures**<br>**For cornea, skin, or cartilage transplants:**<br>*The Covered Person, who is the transplant recipient, must receive 2 opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.* | 80% | 60% |
| **For all other Organ and Tissue Transplants:**<br>*For specific details on all elements of this coverage, Please refer to the Transplants section.*<br>*Note:* $50,000 *maximum benefit* per Calendar year for a *facility* that is not a Centers of Excellence *facility.* | Coverage and Benefit Level based upon place and type of service. | Not Covered. |
| **Organ and Tissue Transplant Travel, Meals and Lodging**<br>*Limitation: $200 maximum benefit per day and $10,000 per lifetime.* | 100%<br>Deductible Waived | 100%<br>Deductible Waived |

## VIII. OTHER COVERED SERVICES:

| **COVERED SERVICES and PROVISIONS**<br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered services and Provisions.**<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), covered services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Orthotics**<br>*Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a covered expense. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless a physiological change in the patient's condition necessitates earlier replacement* | 80% | 60% |
| **Private Duty Nursing Services**<br>*Includes services of a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.), when Medically Necessary, other than one who ordinarily resides in your home, or who is a member of the immediate family.* | 80% | 60% |
| **Professional Ambulance Service**<br>*Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.* | 80% | 60% |
| **Prosthetic Medical Appliances**<br>*Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.* | 80% | 60% |
| **Routine Newborn Nursery Care** *(including circumcision)* | 80% | 60% |
| ***Services/Items for Covered Persons Residing Outside the PPO Network Area*** | *N/A* | *Paid same as any other In-Network service according to type of service, provider and place of service.* |
| **Skilled Nursing Facility**<br>*Includes Extended Care Facility.*<br>*Limited to 81 days per Covered Person per Calendar Year.*<br>*Limited to the usual charge of the facility for semi-private care, including room and board and all other services.* | 80% | 60% |
| **Sleep Disorders**<br>*Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.* | 80% | 60% |
| **Sleep Studies (*home)*** | 80% | 60% |

## VIII. OTHER COVERED SERVICES:

| **COVERED SERVICES and PROVISIONS**<br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered services and Provisions.**<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), covered services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Sleep Studies *(In-lab, facility)*** *In order to be eligible, the following criteria must be met:*<br>• *Excessive daytime sleepiness*<br>• *Epworth sleepiness scale ≥ 10*<br>• *Witnessed snoring*<br>*Along with one of the following comorbid conditions:*<br>• *Chronic obstructive pulmonary disease*<br>• *Neuromuscular disease*<br>• *Stroke*<br>• *Epilepsy*<br>• *Congestive heart failure*<br>• *BMI > 45*<br>• *Periodic limb movement disorder*<br>• *Narcolepsy*<br>• *Central or complex sleep apnea* | 80% | 60% |
| **TMJ** *(Temporomandibular Joint Dysfunction)* | 80% | 60% |
| **Wigs** | Not Covered | |

**Please Refer to the Pre-Certification Program, Prescription Drug Benefit, Transplants, and Exclusions sections for additional coverage details.**

# PRESCRIPTION DRUG BENEFIT

Note: Retirees over age 65 are not eligible for the prescription drug plan benefits.

Prescription drug benefits are provided through the pharmacy benefit plan manager listed in the Prescription Drug Benefit section of the Schedule of Covered services and Provisions. Benefits will be paid as stated in the Schedule of Covered services and Provisions for charges made by a participating pharmacy for treatment of a Covered Person's Illness or Injury. A covered charge is considered made on the date the prescription is dispensed by the pharmacist.

## GENERAL PHARMACY BENEFIT

Prescriptions Covered:

1. Drugs prescribed by a Physician that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the Plan.
2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Insulin.
4. Allergy serums.
5. Oral contraceptives, regardless of the reason prescribed.
6. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a qualified prescriber.

The following prescription expenses are not Covered Expenses:

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.
2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
3. Immunization agents or biological sera, blood or blood plasma, except if purchased through the Specialty Pharmacy Program.
4. A drug or medicine labeled: "Caution - limited by federal law to investigational use."
5. Experimental drugs and medicines, even though a charge is made to the Covered Person.
6. Any charge for the administration of a covered prescription drug.
7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

8. A drug or medicine that is to be taken by the Covered Person, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for dispensing drugs.
9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
10. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches.
11. A charge for contraceptive devices or injectable contraceptives.
12. A charge for legend vitamins, except pre-natal legend vitamins.
13. A charge for minerals.
14. A charge for fluoride supplements.
15. A charge for Minoxidil.
16. A charge for weight loss drugs.
17. A charge for non-legend drugs, other than as specifically listed herein.
18. A charge for Levonorgestrel (Norplant implants).
19. A charge for Hematinics.
20. A charge for Viagra.

## MAIL ORDER DRUG BENEFIT

This benefit offers a mail order service which delivers required prescription drugs directly to Your home after a per prescription co-pay has been made (see Schedule of Covered Services and Provisions for co-pay amount). The mail order drug benefit permits up to a 91-day supply of medication and up to one year of refills upon authorization.

You should receive a packet providing complete details on how to use Your mail order drug benefit. If You have any questions regarding this aspect of Your coverage, please contact the Administrative Manager.

## SPECIALTY DRUG PHARMACY BENEFIT

Certain specialty medications may be required to be purchased through Your pharmacy vendor's or Allied's specialty pharmacy program. Typically, these medications are very costly, require special storage or handling, are for long term use, or require careful monitoring and management. You will be notified by the pharmacy at the time of purchase if a particular drug is in this specialty pharmacy program, or You may call the pharmacy vendor (see Your member ID card) as soon as a drug has been prescribed to determine how it must be dispensed. The specialty pharmacy unit will coordinate fast shipment to the location a member chooses, such as Your home or Your Physician's office. Alternatively, if Your pharmacy vendor indicates that they cannot dispense the drug, please contact Allied's customer service team (see Your member ID card) to determine how the specialty drug that has been prescribed must be dispensed. Please refer to previous pages for coverage provisions.

# TRANSPLANTS

**PREFERRED TRANSPLANT NETWORK FACILITY:**

A Preferred Transplant Network Facility is a facility contracted with the Plan's Preferred Transplant Network (PTN) to furnish particular services and supplies to You or Your Dependent in connection with one or more highly specialized medical procedures. The maximum charge made by the PTN for such services and supplies will be the amount agreed to between the Plan's PTN and the PTN facility.

**TRANSPLANT EXPENSES**

Once it has been determined that You or one of Your Dependents may require an ***organ*** transplant, You or Your Physician should follow the guidelines listed in the Pre-Certification Program to coordinate Your transplant care. You must follow any pre-certification requirements. ***Organ*** means solid organ, stem cell, bone marrow, or tissue.

While all organ transplants (other than cornea or skin transplants) are covered only under this section, benefits may vary if a PTN facility or non-PTN facility is used. The PTN facility must be specifically approved and designated by the PTN to perform the procedure You require. A transplant will be covered as in-network only if performed in a facility that has been designated as a PTN facility for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as a PTN facility, even if the facility is considered as a network facility for other types of services, will not be considered in-network. Additionally, if a PTN facility is utilized, You may be eligible for certain travel benefits related to the organ transplant.

## COVERED TRANSPLANT EXPENSES

Covered transplant expenses include the following (unless stipulated otherwise by a separate transplant agreement between the Plan, PTN, and PTN facility):

- Inpatient and Outpatient expenses directly related to a transplant**.**
- Charges made by a Physician or transplant team.
- Charges made by a Hospital**,** outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the PTN facility during the transplant process. These services and supplies may include: physical therapy, speech therapy and occupational therapy; bio-medicals and immunosuppressants; and home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date You are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes Inpatient and Outpatient services for all covered transplant-related health services and supplies provided to You and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during Your Inpatient stay or Outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during Your Inpatient stay or Outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following organ transplants will be considered one Transplant Occurrence:

- Heart transplant.
- Lung transplant.
- Heart/lung transplant.
- Simultaneous Pancreas Kidney (SPK) transplant.
- Pancreas transplant.
- Kidney transplant.
- Liver transplant.
- Intestine transplant.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant surgery.
- Sequential transplants.
- Re-transplant of same organ type within 180 days of the first transplant.
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be more than one Transplant Occurrence:

- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

***Limitations***

The transplant coverage does not include charges for:

- Outpatient drugs, including bio-medicals and immunosuppressants, not expressly related to an Outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.
- For donor services if You or Your covered Dependent are a donor.

# LIFE INSURANCE BENEFIT

Life insurance benefits are provided through a policy with Trustmark Life Insurance Company, PO Box 7948, Lake Forest, IL 60045-7948. The amount of life insurance payable is $15,000 for active eligible employees and $5,000 for retired eligible employees.

**CLAIM PAYMENT**

The life insurance benefit will be paid when proof of death is received. Benefits will be paid to the beneficiary designated by the employee in writing to the fund office. If no beneficiary is designated, or if the employee outlives the beneficiary, benefits will be paid to the first of the following surviving person: (a) spouse, (b) children, (c) parents, (d) brothers and sisters, (e) executors or administrators.

# ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Benefits are payable for the employee's death, dismemberment and loss of sight due to injury. The Principal Sum is $15,000 and payable for any losses set forth in the Table of Losses (below) which result solely from injury that occurs while the Employee is covered under this benefit is in force and occurs within 90 days after the injury causing the loss.

*With regard to loss of hands and feet, loss means complete severance through or above the wrist or ankle joint. With regard to eyes, loss means entire and irrecoverable loss of sight.

Table of Losses

| | |
|---|---|
| Loss of Life | The Principal Sum |
| Loss of Both Hands | The Principal Sum |
| Loss of Both Feet | The Principal Sum |
| Loss of One Hand and One Foot | The Principal Sum |
| Loss of One Eye and One Foot | The Principal Sum |
| Loss of One Eye and One Hand | The Principal Sum |
| Loss of Sight of Both Eyes | The Principal Sum |
| Loss of One Hand | One-half the Principal Sum |
| Loss of One Foot | One-half the Principal Sum |
| Loss of Sight of One Eye | One-half the Principal Sum |

Accidental Death and Dismemberment coverage and benefits are not assignable.

**EXCLUSIONS**

No Life or AD&D Benefit will be paid for (a) intentionally self-inflicted injury while sane or insane; (b) suicide or attempted suicide while sane or insane; (c) loss resulting from your commission of or attempt to commit a felony; (d) loss resulting from your being engaged in an illegal occupation; (e) injury resulting from travel in any type of aircraft except as a fare-paying

passenger in a commercial aircraft; (f) war or act of war declared or undeclared; (g) bodily or mental infirmity, disease, any type of hernia or bacterial infections, except pyogenic infections which occur with and through an accidental cut or wound and infections resulting from accidental ingestion of poisonous food substances; (h) medical or surgical treatment except loss from surgery performed solely due to and within 90 days of a covered injury; (i) loss to which a contributing cause is the use of any drug, narcotic or hallucinogen not prescribed for you by a physician or not used in the manner prescribed by the physician; or (j) loss resulting from occupational injury.

## SHORT TERM DISABILITY

Short Term Disability benefits are currently provided through a policy with MetLife Insurance Company for all active, eligible, full-time employees for whom benefits are in effect. To be eligible for a weekly benefit, you must be disabled and unable to work in the trade or perform any other gainful employment.

| | |
|---|---|
| Weekly Benefit | 60% of your earnings |
| Maximum Weekly Benefit | $400 |
| Minimum Weekly Benefit | $20 |
| Waiting Period | 7 days for injury, 7 days for sickness |
| Maximum Benefit Period | 26 weeks |
| Rehabilitation Incentives | Yes |

# EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions *(unless specifically stated within the Schedule of Covered Services and Provisions*):

1. for or in connection with an Injury or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation, Occupational Disease, or similar law;
2. for care and treatment of an Injury or Illness arising out of, or in the course of, any employment for wage or profit;
3. in a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;
4. for charges for an Injury sustained or Illness contracted while on active duty in military service, unless payment is legally required;
5. for charges in connection with any Illness or Injury of the covered person resulting from or occurring during commission or attempted commission of a criminal battery or felony by the covered person. This exclusion will not apply to an Illness and/or Injury sustained due to a medical condition (physical or mental) or domestic violence;
6. To the extent that payment under this Plan is prohibited by any law of any jurisdiction in which the Covered Person resides at the time the expense is incurred;
7. for charges which the Covered Person is not legally required to pay or for charges which would not have been made if no coverage had existed;
8. which are not Reasonable and/or in excess of Usual and Customary Charges (depending on contract provisions, this limitation may not apply to charges from network providers or non-network providers who are utilized as a result of requests or requirements of network providers);
9. which are for care or treatment which is not Medically Necessary;
10. for custodial care (Expenses incurred to assist a person in daily living activities are considered costs for custodial care. Costs for medical maintenance services and supplies in connection with custodial care due to age, mental or physical conditions, are not covered if such care cannot reasonably be expected to improve a medical condition.);
11. for charges for services, treatment or supplies for treatment of Illness or Injury which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
12. for purchase or rental of personal comfort items or supplies of common use whether or not recommended by a Physician; for purchase or rental of blood pressure kits, exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steam rooms and/or swimming pools;

13. for non-medical expenses such as preparing medical reports, missed appointments, itemized bills or charges for mailing;
14. for training, educational instructions or materials, even if they are performed or prescribed by a Physician (except as stated in the Schedule of Covered services);
15. for legal fees and expenses incurred in obtaining medical treatment;
16. for genetic testing and counseling (except as may be specifically stated as covered elsewhere in this document);
17. for Friday and Saturday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24 hour period immediately following admission;
18. for treatment by a Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N) if the Physician or nurse is related by blood, marriage, or by legal adoption to either the Covered Person or a spouse, or ordinarily resides with the Covered Person;
19. for any expense in excess of any maximum or limit as stated elsewhere in this document;
20. for failure to provide any additional documentation or information as may be requested pursuant to the "Procedures For Filing Claims" section of this Plan;
21. for charges for travel or accommodations, whether or not recommended by a Physician, unless specifically stated as covered;
22. for charges incurred before coverage was effective or after it was terminated;
21. Except as specifically stated in Schedule of Covered Services, Dental Services, charges for or in connection with: treatment of Injury or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants;
22. for research studies not reasonably necessary to the treatment of an Illness or Injury;
23. for occupational therapy when it is not a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function;
24. for speech therapy when it is rendered for other than the correction of a physical impairment caused by Illness, Injury or congenital deformity;
25. Charges for treatment or surgery for sexual dysfunction or inadequacies unless related to Injury or Illness;
26. for vitamins (except prescription pre-natal and pediatric vitamins); for over-the-counter drugs regardless of being prescribed by a Physician, except as specifically stated under the Prescription Drug Card Program;
27. for routine foot care such as removal of corns, calluses or toenails, except in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy;
28. for splints or braces for non-medical purposes (i.e. supports worn primarily during participation in sports or similar physical activities);

29. for any form of medication or treatment not prescribed in relation to an Injury, Illness or pregnancy, unless stated as covered elsewhere in this document
30. for growth hormones for children with short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
31. for charges in connection with Cosmetic Surgery/Treatment, except to correct deformities resulting from Injuries sustained in an accident; or due to an Illness such as breast cancer (including all services mandated by federal provisions related to mastectomy treatment – see definition of "Reconstructive Breast Surgery Coverage"); or to correct a functional disorder (functional disorders do not include mental or emotional distress related to a physical condition); or unless treatment is for correction of a functional abnormal congenital condition;
32. This Exclusion is intentionally left blank;
33. for expenses incurred for cryo-preservation and storage of sperm, eggs and embryos;
34. for charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies;
35. for special education services (unless specifically referenced in the Schedule of Covered Services);
36. for counseling pertaining to developmental delay, learning deficiencies or behavioral problems unless:
    - the diagnosis is listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered, and
    - the treatment provided and the provider of such treatment is not excluded under any other provisions of the Plan;
37. for experimental or investigational services; or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States;
38. for routine eye examinations; for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses; for any procedure, treatment or exam in connection with refractive disorders; for eye surgery such as radial keratotomy;
39. for charges to determine hearing loss; for hearing aids, or the fitting thereof;
40. for instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician;
41. for the surgery or treatment of obesity except as stated in the Schedule of Covered Services;
42. for services, supplies or treatment for the reversal of surgical sterilizations; for contraceptive devices (except as indicated under the "Prescription Drug Benefit");

43. for “nicotine patches” or other forms of anti-smoking medication or treatment (except as stated in the “Prescription Drug Benefit”);
44. for services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;
45. for marital counseling services;
46. This Exclusion is intentionally left blank;
47. for provider charges claimed as a result of purported lost discounts;
48. for charges related to acupuncture treatment;
49. for Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts;
50. for charges for routine or periodic physical examinations, such as employment physical, or any related charges, such as premarital lab work, and other care not associated with treatment or diagnosis of an Illness or Injury, except as specified herein;
51. for charges for treatment of temporomandibular joint dysfunction and myofascial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and prosthetic devices;
52. for charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth, except as specified herein;
53. for charges for expenses related to hypnosis;
54. for charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a Covered Person under this Plan, except as specified herein;
55. for charges for professional services billed by a professional provider who is an employee of a Hospital or any other facility and who is paid by the Hospital or other facility for the service provided;
56. for charges for Illnesses or Injuries suffered by a covered person due to the action or inaction of any party if the covered person fails to provide information as specified in the section, Subrogation/Reimbursement;
57. for charges for environmental change including Hospital or Physician charges connected with prescribing an environmental change;
58. for charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example);
59. for charges for chelation therapy, except as treatment of heavy metal poisoning;
60. for charges for massage therapy, sex therapy, diversional therapy or recreational therapy;
61. for charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery;
62. for charges for holistic medicines or providers of naturopathy;
63. for charges for structural changes to a house or vehicle;

64. for charges for exercise programs for treatment of any condition;

65. for charges for or related to the following types of treatment:
    a. primal therapy;
    b. rolfing;
    c. psychodrama;
    d. megavitamin therapy;
    e. visual perceptual training.

66. for charges for oral nutrition including infant formula.

# DEFINITIONS

***Certain words and terms used herein shall be defined as follows:***

**AMBULATORY SURGICAL CENTER**

Any private or public establishment with: a) an organized medical staff of Physicians; b) permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient surgical procedures; c) continuous Physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

**ASC REIMBURSEMENT FEE SCHEDULE**

The ambulatory surgical center reimbursement rate set by Centers for Medicare and Medicaid Services (CMS).

**CALENDAR YEAR**

That period of time commencing at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new Calendar Year.

**CASE MANAGEMENT PROGRAM**

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of in-Hospital treatment.

If, at any point in the progress of a given medical situation, after having considered the opinions of the Covered Person (and/or his legally responsible representatives), the Covered Person's Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

**CLAIMS PROCESSOR**

The entity providing consulting services to the Board of Trustees in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Processor is Allied Benefit Systems, LLC, P. O. Box 909786-60690, Chicago, IL 60690.

**COMPANY**

See the Key Information section at the beginning of this document.

**COSMETIC SURGERY/TREATMENT**

Surgery or treatment that is intended to improve the appearance of a patient or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease (except when necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an accident or trauma, or a disfiguring disease).

**COVERED PERSON**

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Company employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

**COVERED SERVICES**

These are expenses for certain Hospital and other medical services and supplies for the treatment of Injury or Illness. A detailed list of Covered Services is set forth in this booklet in the section entitled "Schedule of Covered Services and Provisions."

**DEDUCTIBLE/CO-INSURANCE**

The amount of eligible expense incurred in any Calendar Year, which must be satisfied by the Covered Person before benefits are paid. Upon receipt of satisfactory proof that a Covered Person has incurred Covered Services as a result of an Injury or Illness, the Plan, after deducting the Deductible amount shown in the Schedule of Covered Services and Provisions from the Covered Services first incurred during that Calendar Year, will pay benefits at the appropriate Co-Insurance level as shown in the Schedule of Covered Services and Provisions.

**DEPENDENTS**

Spouse of the Employee who is a resident of the same country in which the Employee resides. For additional information, see the Key Information section at the beginning of this document.

Children from birth to the last day of the month they attain age 26. The term *"child"* or *"children"* include children that are specified within the Key Information section at the beginning of this document.

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Board of Trustees must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

**DOMESTIC PARTNER**

See the Key Information section at the beginning of this document.

**ELECTIVE SURGICAL PROCEDURE**
Any non-emergency surgical procedure which may be scheduled at a patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions and which is performed while the patient is confined in a Hospital as an Inpatient or in an Ambulatory Surgical Center.

**EMERGENCY ROOM SERVICES**
**"**Emergency Room Services**"** is defined as, with respect to a Medical Emergency, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and such further 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.

**EMPLOYEE**
See the Key Information section at the beginning of this document.

**EMPLOYER**
See the Key Information section at the beginning of this document.

**ENROLLMENT DATE**
The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**ESSENTIAL HEALTH BENEFITS**
"Essential Health Benefits" include the following general categories and the items and services covered within the categories: 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.

**EXTENDED CARE FACILITY**
An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the elderly, persons with substance use disorders, intellectually disabled persons, or a place for rest, custodial or educational care or for the care of mental disorders.

**FAMILY DEDUCTIBLE**

If the amount of Covered Services incurred by family members and applied toward the Deductible totals the amount shown in the Schedule of Covered Services and Provisions, the Deductible amount shall be waived for all other members of that family unit for that Calendar Year.

**GENDER NEUTRAL WORDING**

A masculine pronoun in this document shall at all times be considered synonymous with a feminine pronoun unless the context indicates otherwise.

**GENETIC INFORMATION**

The term "genetic information" is defined as 1) an individual's own genetic tests, 2) the genetic tests of family members of such individual, and 3) the manifestation of a disease or disorder in family members of such individual. The term “genetic information” also encompasses family medical history. The term "genetic information" additionally extends to genetic information of any fetus carried by a pregnant woman. With respect to an individual or family member utilizing an assisted reproductive technology, genetic information includes the genetic information of any embryo legally held by the individual or family member. The term “genetic information” further extends to dependents and family members defined as first-degree, second-degree, third-degree, or fourth-degree relatives of the individual. The term additionally includes participation in clinical research involving genetic services.

**HOME HEALTH CARE AGENCY**

A public or private agency that is primarily engaged in providing skilled nursing and other therapeutic services and is either (1) licensed or certified as a home health agency by the governing jurisdiction; or (2) certified as a home health agency by Medicare.

**HOSPICE**

A facility established to furnish terminally ill patients a coordinated program of Inpatient and home care of a palliative and supportive nature. A hospice must be approved as meeting established standards, including any legal licensing requirements.

**HOSPITAL**

An institution which meets all of the following requirements; (a) maintains permanent and full-time facilities for bed care of resident patients; (b) has a doctor in regular attendance; (c) continuously provides 24 hour a day nursing services by Registered Nurses (R.N.); (d) is primarily engaged in providing diagnostic and therapeutic services and facilities for medical and surgical care of Injuries or Illnesses on a basis other than a rest home, nursing home, convalescent home, or a home for the aged; (e) maintains facilities on the premises for surgery; (f) is operating lawfully as a Hospital in the jurisdiction where it is located; and (g) is either accredited by the Joint Commission on the Accreditation of Healthcare Organizations or is Medicare approved.

In addition, the term "Hospital" shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

**HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT**

Only a section, ward or wing within the Hospital which is distinguishable from other Hospital facilities because it (a) is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients, including constant observation and care by a Registered Nurse (R.N.) or other highly trained Hospital personnel, and (b) has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

**HOSPITAL SEMI-PRIVATE**

The room and board charge is not to exceed the semi-private room rate. The difference between the semi-private room rate and the private room rate will be the patient's responsibility and will not apply to, or be affected by, any Out-of-Pocket Maximum provision. However, if 1) a private room is required due to Medical Necessity, or 2) If Hospital has private rooms only, maximum eligible expense will be 90% of lowest private room charge.

**ILLNESS**

Only non-occupational sickness, disease, mental infirmity, or pregnancy (including surrogacy), all of which require treatment by a Physician.

**INJURY**

Only non-occupational bodily Injury which requires treatment by a Physician.

**INPATIENT**

A Covered Person shall be considered to be an "Inpatient" if he is treated at a Hospital and is confined for 23 or more consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by the patient's Physician as an alternative to Hospital confinement.

**LATE ENROLLMENT**

An enrollment which takes place other than during the first period during which an individual was eligible for coverage, or other than during a period of Special Enrollment or Open Enrollment. See the Key Information section at the beginning of this document for applicability.

**LIFETIME**

Shall mean, "while covered under the Plan". Under no circumstances will the word "Lifetime" mean "during the lifetime of the Covered Person".

**MEDICAL EMERGENCY**

A **"**Medical Emergency**"** is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

**MEDICALLY NECESSARY**

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

**MEDICARE DRG OR APC REIMBURSEMENT RATE**

The inpatient and outpatient reimbursement rates set by Centers for Medicare and Medicaid Services (CMS).

**MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES**

Services for diagnoses that are listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered.

**NAMED FIDUCIARY**

The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Board of Trustees, who is the sponsor of this Plan.

In exercising its fiduciary responsibilities, the Board of Trustees shall have sole, full and final discretionary authority to determine eligibility for benefits, review denied claims for benefits, construe and interpret all Plan provisions, construe disputed Plan terms, select managed care options, determine all questions of fact and law arising under this Plan, and to administer the Plan's subrogation and reimbursement rights. The Board of Trustees shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

**OPEN ENROLLMENT**

Each year, a period of time may be designated as an "Open Enrollment" period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. Coverage will become effective on the date specified by your Employer. See the Key Information section at the beginning of this document for applicability, as well as your Employer for details.

**OUT-OF-POCKET MAXIMUM**

The "Out-of-Pocket Maximum" is the total amount of co-pays, co-insurance and deductibles for which the Covered Person or covered family is responsible during the course of a Calendar Year. These amounts are shown in the "Schedule of Covered Services and Provisions," along with expenses not applicable towards the Out-of-Pocket maximum.

**OUTPATIENT**

A Covered Person shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 23 consecutive hours.

**PHYSICIAN**

A Physician who is duly qualified and licensed by the state in which he is resident to practice medicine, perform surgery and to prescribe drugs, or who is licensed to practice as a dentist, podiatrist, chiropractor, psychologist, social worker or practitioner of healing arts, and who is practicing within the scope of his license.

**PLACEMENT FOR ADOPTION**

The assumption and retention of a legal obligation for total or partial support in anticipation of adoption.

**PLAN**

The benefits and provisions for payment of same as described herein are the Employer Plan as described in the Key Information section at the beginning of this document. This is a Group Health Plan.

**PLAN ADMINISTRATOR**

The entity responsible for the day-to-day functions and overall management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services. The Plan Administrator is the Board of Trustees.

**PLAN YEAR**

The 12-month period defined in the Key Information section at the beginning of this document. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section.

**QUALIFIED MEDICAL CHILD SUPPORT ORDER**

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If your employer determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO, and your current plan offers dependent coverage, you will be required to provide coverage for any child(ren) named in the QMCSO. If you do not enroll the child(ren), your employer must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to your employer that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). ERISA preemption of state laws does not apply to Qualified Medical Child Support Orders and provisions of state laws requiring medical child support. Group health plans may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning "QMCSO" procedures are available from the Plan Administrator at no charge upon request.

**REASONABLE/REASONABLENESS**

"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or charges for services or supplies, which are necessary for the care and treatment of Illness or Injury. Determination that charges or services/supplies are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and/or the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination may consider, but not be limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, services, supplies and/or charges must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether services, supplies and/or charges are Reasonable based upon information presented to the Plan Administrator.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, and to identify charges and/or services that are not Reasonable, and therefore not eligible for payment by the Plan.

**RECONSTRUCTIVE BREAST SURGERY COVERAGE**

Medical benefits under the Plan will be administered according to the terms of the Women's Health and Cancer Rights Act of 1998. The Plan will provide to Covered Persons who are receiving Plan benefits in connection with such mastectomy coverage for: (1) all stages of reconstruction

of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. The coverage will be subject to the terms of the Plan established for other coverage under the Plan, including the annual deductible and coinsurance provisions.

**RETIREE**
See the Key Information section at the beginning of this document.

**SECOND SURGICAL OPINION**
Shall mean a written statement on the necessity for the performance of a covered surgical procedure. This Second Surgical Opinion must be given by a board-certified specialist who, by the nature of the Physician's specialty, qualifies the Physician to consider the surgical procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the surgery.

**SPECIAL ENROLLMENT**
An enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See "Eligibility" section for details.

**SWITCH ENROLLMENT**
Each year, a period of time may be designated as a "Switch Enrollment" period. Except for Special Enrollment, it is only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by your Employer. See the Key Information section at the beginning of this document for applicability, as well as your Employer for details.

**USUAL AND CUSTOMARY**
"Usual and Customary" (U&C) shall mean Covered Services which are identified by the Plan Administrator, taking into consideration the charge(s) which the provider most frequently bills the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the prevailing range of charges billed in the same "area" by providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, service, or supply for which a specific charge is made. To be Usual and Customary, the charge must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a provider of services or supplies. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

**WAITING PERIOD**

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period.

# ELIGIBILITY

## WHO IS ELIGIBLE

See the Key Information section at the beginning of this document.

## NON-DISCRIMINATION

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

## STANDARD EMPLOYEE COVERAGE

For date of eligibility, please see the Key Information section at the beginning of this document. Providing a new employee is actively at work on at least the first day of employment, the Plan will not exclude absences from work due to health related reasons from credit towards the waiting period, if applicable, as referenced in the Key Information section.

## STANDARD DEPENDENT COVERAGE

Each Dependent of the eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:

1. The date the Employee is eligible; or
2. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

## STANDARD INDIVIDUAL EFFECTIVE DATE

All persons become covered, as they become eligible subject to the following:

1. All Employees, who are eligible Employees, shall be covered on the day they become eligible, as discussed in the Key Information section at the beginning of this document.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will begin from the date of Placement for Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of "Dependent." With respect to a spouse, the spouse must be formally enrolled and appropriate coverage

arranged within 30 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 30 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date that the child meets the definition of "Dependent."

**OPEN ENROLLMENT**

See the Key Information section at the beginning of this document for applicability.

**LATE ENROLLMENT**

See the Key Information section at the beginning of this document for applicability.

**SPECIAL ENROLLMENT**

The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a late enrollee.

An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and lose that coverage. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance (CHIP) program with respect to this Plan.

If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended. Loss of eligibility includes a loss of coverage due to:

- divorce;
- legal separation;
- death;
- termination of employment, or reduction in hours of employment;
- Change in the cost of coverage under the employer's group medical plan;

- Significant change in the health coverage of the employee or spouse attributable to the spouse's employment;
- A court order, judgment or decree
- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals;
- the Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the employee or dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 30 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

**SWITCH ENROLLMENT**

See the Key Information section at the beginning of this document for applicability.

**TERMINATION OF COVERAGE**

See the Key Information section at the beginning of this document for details.

# EMPLOYER POLICIES AND PROCEDURES

Except as required under the Americans with Disabilities Act, the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Board of Trustees' policies and procedures regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified disability, leave of absence, layoff, reinstatement, hire or rehire. Whether an Employee works the requisite hours of service to be eligible for coverage shall be determined in accordance with the policies and procedures of the Board of Trustees.

# NETWORK BENEFITS

Your Plan contains enhanced benefits through network providers. The name of the organization associated with these network providers is indicated on the front of Your ID card, along with instructions regarding where to file medical claims. Benefits are generally paid at a higher level when using network Hospitals and network Physicians than when using non-network providers. Please refer to the Schedule of Covered Services for benefits payable according to type of provider used. Note: A printed listing of network providers will be furnished automatically, without charge, as a separate document by the Plan Administrator.

A Covered Person has a free choice of any provider for medical care. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan.

# PROCEDURES FOR FILING CLAIMS

Remember to Pre-Certify by calling the toll-free number shown on your ID card if required by your Plan.

**KEY POINTS TO REMEMBER**

The claims filing address you must use for filing all medical claims is shown on your ID card.

1. Each bill should be itemized as to services, show payment status, and include the name of the patient, the Employee's social security number or unique identification number ("UID"), and the name and/or group number of the Employer.
2. It is your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
3. All charges, and corresponding requested documentation, must be submitted within the time frame specified in the Schedule of Covered Services and Provisions. Failure to do so will result in the denial of the charges.
4. From time to time, additional information may be requested to process your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, accident details, police reports, etc. must be submitted by you or your provider(s) when requested within the time frame specified in the Schedule of Covered Services and Provisions. Your failure to do so will result in the denial of the claim.
5. Only clean claims will be adjudicated by the Plan. A clean claim is one that is complete and accurate, does not require further information for processing from the provider, patient, or any other person or entity, and leaves no issues regarding the Plan's responsibility for payment.
6. A Claim will not be considered if the charges were incurred prior to 12 months before submission.
7. Urgent care claims: The Plan will defer to the attending provider regarding the decision as to whether the claim constitutes an urgent care claim. Clean urgent care claims will be determined by the Plan as soon as possible (taking into account medical exigencies), but not later than 72 hours after receipt of the claim. For incomplete or incorrectly filed urgent care claims, You will be notified of the proper procedures to follow as soon as possible but no later than 24 hours after receipt of the claim.

**FILING A HOSPITAL CLAIM**

When a Covered Person is admitted as an Inpatient or is treated as an Outpatient, secure an itemized Hospital bill, including an admitting diagnosis. Check your bill for any possible errors and then submit the charges as indicated above.

Always retain a copy of the hospital bill for your records.

**MISCELLANEOUS CLAIMS FILING CONSIDERATIONS**

It is necessary to keep separate records of your expenses with respect to each of your Dependents and yourself. The following items are important and should be carefully kept to be submitted with your claim:

1. All Physician's bills should show the following:
    a. Name of patient and adequate membership information
    b. Dates and charges for services, and payment status of each
    c. Types of service rendered and procedure codes
    d. Diagnosis information

2. Prescription drug expenses should show the following:
    a. Name of patient and adequate membership information
    b. Prescription number and name of drug
    c. Cost of the drug and date of purchase. Cash register receipts and canceled checks cannot be accepted for payment
    d. Generic Drugs should be indicated on the drug bill

3. Bills for all other covered medical charges, such as for ambulance service, durable medical equipment, etc. should show the following:
    a. Name of patient and adequate membership information
    b. Date of service
    c. Charge and description of each service/item
    d. Diagnosis information

Always retain a copy of the bill for your records.

# THIS PLAN AND MEDICARE

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. If the Employee is still actively at work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
5. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

# GENERAL PROVISIONS – SHORT TERM DISABILITY

**ADMINISTRATION OF THE PLAN**

The Plan is administered by the Board of Trustees. The Board has retained the services of an independent Claims Processor experienced in claims processing. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section at the beginning of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator at the address specified in the Key Information section at the beginning of this document.

**APPEALING A CLAIM**

**CLAIMS PROCEDURES**

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination". An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An Adverse Benefit Determination is subject to the provisions detailed below.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information.

A notice of Adverse Benefit Determination will include the following:

- The specific reason or reasons for the adverse determination.
- Reference to specific plan provisions on which the adverse determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of claimant's right to bring a civil action under Section 502(a) of ERISA following a determination on appeal.

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

**APPEALS PROCEDURE**

If you receive an Adverse Benefit Determination, you or your authorized representative may appeal the determination by filing a written application with the Plan Administrator. In appealing an Adverse Benefit Determination, the Plan Administrator will provide you or your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give You a reasonable opportunity to respond prior to that date.
- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

**An appeal must be filed within 180 days after the Adverse Benefit Determination is received.** The Plan Administrator will notify you or your authorized representative of its determination within 60 days after receipt of an appeal.

The Plan Administrator's determination:

- will be in writing setting forth specific reasons for the decision and reference to the specific plan provisions upon which the determination is based.
- will contain a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- **will contain a statement of your right to bring an action under Section 502(a) of ERISA within one (1) year of the date of the Adverse Benefit Determination**.
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the claims and appeals process with respect to a claim, You are deemed to have exhausted the claims and appeals process (unless the Plan's failure to strictly adhere to these requirements is 1) *de minimis*, 2) non-prejudicial, 3) attributable to good cause or matters beyond the Plan's control, 4) in the context of an ongoing good faith exchange of information, and 5) not reflective of a pattern or practice of non-compliance). Accordingly, upon such a failure, You may pursue any available remedies under applicable law.

To the extent the Plan contends that it did not commit a procedural violation based on the five criteria referenced immediately above, You will be entitled, upon written request, to an explanation of the Plan's basis for such an assertion (to be provided within ten days), so that You can make an informed judgment about whether to seek immediate review from a court of law. Finally, if the court of law rejects Your request for immediate review on the basis that the Plan did not engage in a violation, You have the right to resubmit and pursue the claims and appeals process.

# GENERAL PROVISIONS – PPO SCHEDULE OF COVERED SERVICES AND PROVISIONS

**ADMINISTRATION OF THE PLAN**

The Plan is administered by the Board of Trustees. The Board has retained the services of an independent Claims Processor experienced in claims processing. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section at the beginning of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator at the address specified in the Key Information section at the beginning of this document.

**APPEALING A CLAIM**

**CLAIMS PROCEDURES**

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination" and is subject to the provisions detailed below.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information.

A notice of Adverse Benefit Determination will include the following:

- The specific reason or reasons for the adverse determination.
- Reference to specific plan provisions on which the adverse determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of claimant's right to bring a civil action under Section 502(a) of ERISA following a determination on appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

**APPEALS PROCEDURE**

If you receive an Adverse Benefit Determination, you or your authorized representative may appeal the determination by filing a written application with the Plan Administrator. In appealing an Adverse Benefit Determination, the Plan Administrator will provide you or your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

**An appeal must be filed within 180 days after the Adverse Benefit Determination is received.** The Plan Administrator will notify you or your authorized representative of its determination within 60 days after receipt of an appeal.

The Plan Administrator's determination:

- will be in writing setting forth specific reasons for the decision and reference to the specific plan provisions upon which the determination is based.
- will contain a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

- **will contain a statement of your right to bring an action under Section 502(a) of ERISA within one (1) year of the date of the Adverse Benefit Determination**.
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

  If the Plan denies Your appeal, in whole or in part, and You choose to bring a civil action, such action must be filed within 365 days of the date of the Plan's denial of Your appeal.

**ASSIGNMENT OF BENEFITS**

The Plan will use its best efforts to recognize assignments of benefits from providers of services but is not bound by such assignments. Notwithstanding the foregoing, the Plan will not recognize any assignment of a Covered Person's right to bring a cause of action or otherwise initiate a legal proceeding arising from an adverse benefit determination. When payment is made directly to the Covered Person (with or without an assignment), it is solely the responsibility of the Covered Person to reimburse the provider.

**CLAIM AUDIT**

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

**COMPLIANCE**

The Plan shall comply with all federally mandated benefit laws and regulations pertaining to employee benefit plans. The intent of the Plan is to assure full compliance with all appropriate federal laws, rules and regulations and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional. The Claims Processor shall be fully discharged from liability under this Plan.

**CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS**

See Key Information at the beginning of this booklet.

**CONTRIBUTIONS**

The benefits provided under the terms of this Plan are purchased through assets of The Trust consisting of contributions from contributing Employers, Employees, and investments.

**ERISA AMENDMENTS**

Any provision of this Plan that is in conflict with ERISA, which governs this Plan, shall be deemed amended to conform to the minimum requirements of the law.

**FUNDING**

This Plan is a multiemployer welfare benefit plan funded by contributions from contributing Employers and Employees to provide the benefits described in the Key Information section at the beginning of this document.

**LIENS**

To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

**NO WAIVER**

A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

**PLAN IS NOT A CONTRACT**

The Plan shall not be deemed to constitute a contract between any contributing Employer and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of any contributing Employer or to interfere with the right of any contributing Employer to discharge any Employee as provided under an applicable collective bargaining agreement.

**PLAN AMENDMENT, MODIFICATION OR TERMINATION**

The Board of Trustees reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a duly adopted resolution of the Board of Trustees. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

## PROHIBITION ON RESCISSION

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

## REIMBURSEMENT AND SUBROGATION PROVISIONS

### PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Illness, Injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

However, such payment of benefits by the Plan shall be made only if the Covered Person first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

The Covered Person (including his attorney, and/or legal guardian of a covered minor or incapacitated individual) agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

In addition, the reimbursement amounts due to the Plan are plan assets within the meaning of ERISA and the Covered Person and the Covered Person's attorney are fiduciaries within the meaning of ERISA with respect to such plan assets.

**SUBROGATION**

As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as applied to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person fails to file a claim or pursue damages against:

a) the responsible party, its insurer, or any other source on behalf of that party;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

**RIGHT OF REIMBURSEMENT**

The Plan shall have the specific right of first recovery ("reimbursement"), and as such, shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other equitable and/or legal theory, without regard to whether the Covered Person is fully compensated by his recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

**COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS**

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Covered Person understands that he/she is required to:

a) notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

c) in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

d) hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes his/her obligation to the Plan under this section, the Covered Person or any of his/her agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from his/her general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

**SEPARATION OF FUNDS**

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

**WRONGFUL DEATH**

In the event that the Covered Person dies as a result of his injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

**OBLIGATIONS**

It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b) to provide the Plan with pertinent information regarding the Illness, Injury, or disability, including accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage; and

f) to discharge all fiduciary duties under ERISA with respect to the plan assets over which the Covered Person exercises any authority or control.

If the Covered Person and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's cooperation or adherence to these terms.

**OFFSET**

Failure by the Covered Person and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds, or payments due under this Plan on behalf of the Covered Person may be withheld until the Covered Person satisfies his obligation.

**MINOR STATUS**

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

### SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

## RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

## RIGHTS OF RECOVERY

Whenever payments have been made by the Plan which are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Claims Processor or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

## SEVERABILITY

Should any provision of this Summary Plan Description be declared invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining portions of the Summary Plan Description. Any remaining portions shall remain in full force and effect, as if this Summary Plan Description did not contain the invalid or illegal provision.

## SUBMISSION OF CLAIM

All charges, and corresponding requested documentation, must be submitted by the date specified in the Schedule of Covered Services and Provisions. Failure to do so will result in the denial of the charges.

## SUMMARY OF MATERIAL MODIFICATIONS

Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in covered services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change.

**SUMMARY PLAN DESCRIPTION**

The Board of Trustees will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is intended to satisfy the requirement for both a Summary Plan Description and Plan Description as specified under ERISA.

**SYSTEM FOR PROCESSING CLAIMS**

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, Reasonable and/or Usual and Customary limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

**TYPE OF ADMINISTRATION**

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired an Administrative Manager and a Claims Processor to process claims and provide consulting services and ministerial functions.

# COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. See Schedule of Covered Services and Provisions to determine the type of Coordination of Benefits this Plan provides.

To coordinate benefits, it is necessary to determine in what order the benefits of various plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

   If the parent with custody has not remarried:

   a) The plan of the parent with custody is primary.
   b) The plan of the parent without custody is secondary.

   If the parent with custody has remarried:

   a) The plan of the parent with custody is primary.
   b) The plan of the stepparent with custody is secondary.
   c) The plan of the parent without custody is tertiary (third).

   There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.
5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

To the extent that the Plan would be secondary to Medicare, if a Covered Person is eligible for Medicare and does not elect to enroll for the Medicare coverage, then benefits otherwise payable on behalf of that Covered Person shall be reduced by the amount of benefits available from Medicare, regardless of whether such benefits are actually received from Medicare.

Any other "plan" means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee, Employee benefit association, government agency or professional association; or any homeowner's policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any individual or non-group health coverage, of which the Plan Administrator is actually aware, including but not limited to a plan or policy purchased or made available through a state or federally managed Health Insurance Marketplace; or any coverage provided by a licensed Health Maintenance Organization (HMO); or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term "plan" shall also mean any mandatory "no-fault" automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident; and any other payment received under any automobile policy.

To administer this provision, the Board of Trustees has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party, when the Board of Trustees should have made the payment.

# COMPLIANCE REGULATIONS

## STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

## SOURCE OF INJURY RESTRICTIONS

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

## WELLNESS VS. RISK FACTORS

The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

## FAMILY MEDICAL LEAVE ACT (FMLA)

**The following applies to contributing Employers with 50 or more employees**

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the contributing Employer that the Covered Person does not intend to return to work at the end of the FMLA leave.

The Covered Person may choose not to retain health coverage during the FMLA leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA leave.)

**MILITARY LEAVES**

If you are absent from work due to military service, you may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if you are absent for 30 days or less, your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not you continue coverage during military service, you may reinstate coverage under the Plan on your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that you had not fully completed any required waiting period prior to the start of military service.

**GENETIC INFORMATION**

The Plan may not adjust premium or contribution amounts for those covered under the Plan on the basis of genetic information. The Plan may also not request, require or purchase genetic information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no genetic information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

# NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

**INTRODUCTION**

This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage**. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

**WHAT IS COBRA CONTINUATION COVERAGE?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a “qualifying event”. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Codecan be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employeewill become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**WHEN IS COBRA COVERAGE AVAILABLE?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.**

**HOW IS COBRA COVERAGE PROVIDED?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18 month period of COBRA continuation coverage can be extended.

**DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

**SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?**

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.HealthCare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it’s important that you choose carefully between COBRA continuation coverage and other coverage options, because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

**WHAT IS THE HEALTH INSURANCE MARKETPLACE?**

The Marketplace allows you to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage.

**WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?**

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

**IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?**

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

**WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?**

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

**IF YOU HAVE QUESTIONS**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

**KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.

**PLAN CONTACT INFORMATION**

If you have any questions regarding COBRA Continuation Coverage under the Plan, please contact your Plan Administrator.

# ERISA RIGHTS SECTION

As a Plan participant, you are entitled to certain rights and protection 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 and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Services Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a 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. Your 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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**ENFORCE YOUR RIGHTS**

If your claim for a welfare benefit is denied or ignored, in whole or in part, or if your coverage was rescinded, 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, or

if your coverage was rescinded, you may file suit in a state or Federal court, subject to the procedures discussed in the Section "APPEALING A CLAIM" under "GENERAL PROVISIONS." In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that 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 Services Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Services 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 EBSA.

# STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS")

## ISSUED PURSUANT TO

**The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA")**

**1. Disclosure of Summary Health Information to the Plan Sponsor**

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

**2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes**

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);

b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

   i. The access to and use of PHI by the individuals described in the Key Information section at the beginning of this document shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

   ii. In the event any of the individuals described in the Key Information section do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" functions are activities that would meet the definitions of treatment, payment and health care operations. "Plan Administration" functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, medical necessity reviews, certain appeal determinations, utilization review, case management and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

**3. Disclosure of Certain Enrollment Information to the Plan Sponsor**

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

**4. Other Disclosures and Uses of PHI**

**With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.**

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT COVERED PERSONS MAY BE USED AND DISCLOSED AND HOW COVERED PERSONS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan's legal obligations concerning a Covered Person's protected health information and describes a Covered Person's rights to access, amend and manage that protected health information.

Protected health information ("PHI") is individually identifiable health information, including demographic information, collected from a Covered Person or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Person's past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Person; or (3) the past, present or future payment for the provision of health care to a Covered Person.

This Notice has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document:

**THE PLAN'S RESPONSIBILITIES**

The Plan is required by law to maintain the privacy of a Covered Person's PHI. The Plan is obligated to provide the Covered Person with a copy of this Notice of the Plan's legal duties and of its privacy practices with respect to the Covered Person's PHI, abide by the terms of the Notice that is currently in effect, and notify the Covered Person in the event of a breach of the Covered Person's unsecured PHI. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

**PERMISSIBLE USES AND DISCLOSURES OF PHI**

The following is a description of how the Plan is most likely to use and/or disclose a Covered Person's PHI.

**TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

**TREATMENT**

The Plan will use or disclose PHI so that a Covered Person may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between one or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's primary care physician so that the specialist may request medical records from that primary care physician.

**PAYMENT**

The Plan will use or disclose PHI to pay claims for services provided to a Covered Person and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

**HEALTH CARE OPERATIONS**

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

## POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

## OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

### REQUIRED BY LAW

The Plan may use or disclose PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

### PUBLIC HEALTH ACTIVITIES

The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

### HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

### ABUSE OR NEGLECT

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Covered Person's PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

**LEGAL PROCEEDINGS**

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

**LAW ENFORCEMENT**

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

**CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION ORGANIZATIONS**

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

**RESEARCH**

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

**TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY**

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

**MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES**

Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

**INMATES**

If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Person; (2) the Covered Person's health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

**WORKERS' COMPENSATION**

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

**EMERGENCY SITUATIONS**

The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

**FUNDRAISING ACTIVITIES**

The Plan may use or disclose the PHI of a Covered Person for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does contact the Covered Person for fundraising activities, the Plan will give the Covered Person the opportunity to opt-out, or stop, receiving such communications in the future.

**GROUP HEALTH PLAN DISCLOSURES**

The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Covered Person. The Plan can disclose the PHI of the Covered Person to that entity if that entity has contracted with the Plan to administer the Covered Person's health care program on its behalf.

**UNDERWRITING PURPOSES**

The Plan may use or disclose the PHI of a Covered Person for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Covered Person for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI of the Covered Person that is genetic information.

**OTHERS INVOLVED IN YOUR HEALTH CARE**

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

## REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

### DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

### DISCLOSURES TO COVERED PERSONS

The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: (1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

### BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

**OTHER COVERED ENTITIES**

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

**PLAN SPONSOR**

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

**USES AND DISCLOSURES OF PHI THAT REQUIRE A COVERED PERSON'S AUTHORIZATION**

**SALE OF PHI**

The Plan will request the written authorization of a Covered Person before the Plan makes any disclosure that is deemed a sale of the Covered Person's PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

**MARKETING**

The Plan will request the written authorization of a Covered Person to use or disclose the Covered Person's PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person or when the Plan provides promotional gifts of nominal value.

**PSYCHOTHERAPY NOTES**

The Plan will request the written authorization of a Covered Person to use or disclose any of the Covered Person's psychotherapy notes that the Plan may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Person's written authorization. If the Covered Person provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

## A COVERED PERSON'S RIGHTS

The following is a description of a Covered Person's rights with respect to PHI:

### RIGHT TO REQUEST A RESTRICTION

A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations. The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send the request when the Covered Person's call is received. In this request, it is important that the Covered Person states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

### RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Covered Person believes that a disclosure of all or part of his PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

The Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and (2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document as soon as the Covered Person determines the need to restrict disclosures of his PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

**RIGHT TO INSPECT AND COPY**

A Covered Person has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a request by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Person requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. If a Covered Person is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A licensed health care professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request.

Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

**RIGHT TO AMEND**

If a Covered Person believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Person may request that the Plan amend such information by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. Additionally, this request should include the reason the amendment is necessary. It is important that the Covered Person direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Person has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

**RIGHT OF AN ACCOUNTING**

The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Covered Person may request an accounting by submitting a request in writing to the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

**RIGHT TO A COPY OF THIS NOTICE**

The Covered Person has the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. If you receive this Notice on the Plan's website or by electronic mail, you also are entitled to request a paper copy of this Notice.

**COMPLAINTS**

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A copy of a complaint form is available from this contact office.

A Covered Person also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Covered Person became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

# STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "SECURITY STANDARDS")

## 1. DEFINITIONS

a. The term "Electronic Protected Health Information" ("EPHI") has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.

b. The term "Security Incidents" has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

## 2. PLAN SPONSOR OBLIGATIONS

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and

d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

   i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and

   ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.