# ARIZONA PIPE TRADES

# HEALTH AND WELFARE TRUST FUND

## Summary Plan Description (SPD)/Plan Rules and Regulations for Active Employees and Non-Medicare Retirees

**Amended, restated, and effective April 1, 2025**

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# ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND

## IMPORTANT INFORMATION FOR EARLY RETIREES
## *(RETIREES WHO ARE NOT YET ENTITLED TO MEDICARE)*

### Definition of Early Retiree

An "Early Retiree," is a Participant, other than a Corporate Officer non-jobsite Participant, who has been continuously eligible for Fund benefits for 36 months out of the prior 42 consecutive months (not to include more than six months COBRA self-pay) and who is receiving a pension award from the Arizona Pipe Trades Pension Trust Fund and who is not entitled to Medicare. An Early Retiree may continue to participate in the Medical Plan only if the person so elects, upon timely payment of the proper self-payment rate, as determined by the Board, to the Administrative Office.

Notwithstanding the previous paragraph, an individual who receives a pension award from the Arizona Pipe Trades Pension Trust Fund may also participate in the Medical Plan provided the person was continuously eligible for benefits for a minimum of 25 years under the Arizona Pipe Trades Health and Welfare Trust Fund (Fund). Such person must make application to the Board of Trustees.

**IMPORTANT NOTE:**

THE ELECTION TO PARTICIPATE IN THE MEDICAL PLAN MUST BE MADE AT THE TIME THE INDIVIDUAL FIRST RECEIVES A PENSION AWARD FROM THE ARIZONA PIPE TRADES PENSION TRUST FUND OR ON THE DATE FOLLOWING THE PENSION AWARD IN WHICH THE INDIVIDUAL EXHAUSTS HIS/HER HOUR BANK.

IF THE INDIVIDUAL RETURNS TO WORK AND ESTABLISHES ELIGIBILITY AS AN ACTIVE EMPLOYEE AND THEN LOSES THAT ELIGIBILITY, HE MAY RESUME PARTICIPATION IN THIS PLAN AS AN EARLY RETIREE, UPON PAYMENT OF APPROPRIATE SELF-PAYMENTS, SO LONG AS HE MAINTAINS CONTINUOUS ELIGIBILITY.

AN INDIVIDUAL WHO QUALIFIES UNDER THE 25 CONSECUTIVE YEAR REQUIREMENT (OR HIS/HER SPOUSE) MAY DEFER THE ELECTION TO PARTICIPATE IN THE MEDICAL PLAN PROVIDED THE PERSON RETAINS CONTINUOUS COMPARABLE COVERAGE UP TO THE DATE OF PARTICIPATION IN THE MEDICAL PLAN.

### Coverage for Early Retirees

Continuation of the Medical Plan benefits described in this document applies to an Early Retiree and/or that Early Retiree's eligible Dependents. Payments can be continued until the earliest of the following events occurs:

1. The Fund ceases providing benefits to Early Retirees;
2. The Fund ceases providing any benefits to any Participant;
3. Coverage ceases by reason of failure of the Early Retiree or the eligible Dependent to make timely self-payments (in full) required by the Board of Trustees;
4. Death of the Early Retiree;
5. The Early Retiree or his/her Dependent(s) fails to meet the eligibility requirements of the Plan.

**SPECIAL NOTE: It is extremely important that you apply for Medicare Part A and B PRIOR TO attainment of age 65 or when disabled; otherwise, you may be subject to a delay in the effective date of your Medicare coverage.**

Once an Early Retiree becomes entitled to Medicare and is no longer covered by this Plan, their Dependents who are not eligible for Medicare may continue to be covered under this Plan until they meet the Dependent termination provisions described in Article II on Eligibility.

Generally, the benefits and provisions described in this document pertain to Active Employees, Early Retirees (as that term is defined above) and their eligible Dependents (as that term is defined in Article I on General Definitions) of Active Employees and Early Retirees, except for the provisions noted below that do not pertain to Early Retirees and their eligible Dependents.

## What Benefits Do Not Pertain to Early Retirees?

The following benefits described in this document **do not** pertain to Early Retirees:

- The Dental PPO Plan.
- The Weekly Disability benefits.
- Death and Accidental Death and Dismemberment benefits.

# ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND

## To All Eligible Plan Participants:

We are pleased to provide you with this new document describing the benefits provided by your Health and Welfare Trust Fund. This document describes the Plan and contains both your Summary Plan Description (SPD) and the Plan Rules and Regulations and replaces all other SPD and Plan Rules and Regulation documents previously provided to you.

This document provides a description of the benefits to which you and your family are entitled, the rules governing these benefits and the procedures that should be followed when making a claim. It will help you understand and use the benefits provided by the Fund. You should review it and also show it to those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. **Remember, not every expense you incur for health care is covered by the Plan.**

**All provisions of this document contain important information.** If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in the front of this document.

As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Also included in the back of this document is certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act (ERISA).

**IMPORTANT NOTICE**

You or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, change of address, marriage, divorce or legal separation, death of any covered family member, birth, adoption or placement for adoption of a Dependent child, change in status of a Dependent Child (such as reached the limiting age for eligibility), Medicare enrollment or disenrollment or the existence of other coverage. **Failure to do so may cause both (1) you or your enrolled Dependents to lose certain rights under the Plan and (2) result in the Plan suing you or your enrolled Dependents to recover amounts erroneously paid to an ineligible dependent.**

Please familiarize yourself with the benefits described in this document in order to fully understand the extent of the benefits to which you are entitled. Any questions you have should be directed to the Administrative Office where the staff will be happy to assist you.

Sincerely,

**BOARD OF TRUSTEES**

## AUTHORIZED SOURCE OF INFORMATION

The only source of authorized information is this benefit document that contains the Summary Plan Description and Plan Rules and Regulations, the Agreement and Declaration of Trust (Trust Agreement), and the written statements of the Fund. Statements or representations, including oral conversations made by individuals other than designated personnel are not authoritative sources of information. Questions about eligibility, benefits and other matters should be submitted to the Administrative Office at their address listed on the Quick Reference Chart in the front of this document.

## QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Administrative Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the Administrative Office staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Administrative Office and obtain a written response from the Administrative Office. In the event of any discrepancy between any information that you receive from the Administrative Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

### DISCLAIMER

NOTE: Weekly Disability, comprehensive Medical Plan, Dental PPO Plan and Vision benefits described in this document are self-funded and are not insured by any contract of insurance and there is no liability upon the Board of Trustees or any individual or entity to provide payment over and beyond the amount of the funds collected and available for such purpose.

The Life and Accidental Death and Dismemberment benefits are insured.

The Board of Trustees shall have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and other related matters. The Board of Trustees have full power to construe the provisions of the Agreement and Declaration of Trust for the Fund and the Rules and Regulations of the Plan. Any such determination and any such construction adopted by the Board of Trustees in good faith shall be binding on all of the parties and Beneficiaries of this Fund.

The Summary Plan Description (SPD) portion of the document attempts to highlight the benefits to which you and your eligible Dependents are entitled under this Plan, however, it should be understood that, in all instances, the provisions contained in the Rules and Regulations of this Health and Welfare Plan will govern all claim payments.

Nothing in the SPD portion of this document is meant to interpret or extend or change in any way the provisions expressed in the Rules and Regulations of the Health and Welfare Plan.

The Board of Trustees reserve the right to amend, modify or discontinue all or part of this Plan, whenever, in their judgment, conditions so warrant.

Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. No individual shall have accrued or vested rights to benefits under this Plan. Vested rights refers to benefits that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

## IMPORTANT TERMS

Certain terms used in this document, to describe the individuals eligible or covered for benefits, are ***important.*** These terms are defined in the Definitions Article of this document and outlined below:

- **"Eligible Person(s)"** is the general term applied to **all** individuals covered under the Plan. Eligible persons include Participants and Dependents.
- **"Participant(s) or Plan Participant(s)"** refers only to Active Employees, Retirees, and COBRA Participants who were formerly Active Employees. This definition does not include Dependents.
- **"Dependent(s)"** refers only to an eligible Spouse and Eligible Dependent children.

## FOR HELP OR INFORMATION

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

## QUICK REFERENCE CHART

| Information Needed: | Contact the following: |
|---|---|
| **Administrative Office (Fund Office)**<br>• Eligibility and Plan Benefit information<br>• Claims Administration and appeals of these claims: Dental PPO Plan benefits for Active Employees and their eligible Dependents, and the Vision and/or Dental Benefits for the Early Retirees and their eligible Spouse<br>• Health Reimbursement Arrangement (HRA) administration<br>• Weekly Disability benefits, claims and appeals<br>• Self-pay and COBRA Administration<br>• Medicare Part D Notice of Creditable Coverage<br>• Summary of Benefits and Coverage (SBC)<br>• HIPAA Notice of Privacy Practice | **BeneSys, Inc.**<br>3109 N. 24th Street, Suite 105<br>Phoenix, AZ 85016<br>Phone: 602-956-1950<br>**Toll Free Phone: 1-877-429-7473**<br>Fax: 1-602-956-3016<br>Website: http:///www.azpipe.org<br>Email address: staff@azpipe.org |
| **UA Local 469 Activate Health and Wellness Centers**<br>• Primary and preventive care<br>• On-site labs, immunizations, and medications<br>• Diagnostic testing and vitals<br>• Chronic condition management | **Glendale Clinic**<br>Suite C-136<br>18301 N. 79th Avenue<br>Glendale, AZ 85308<br>623-323-2262<br><br>**Gilbert Clinic**<br>Suite 109<br>3717 S. Rome Street<br>Gilbert, AZ 85297<br>623-274-2400<br><br>**Union Hall Clinic**<br>Suite 101<br>3109 N. 24th Street<br>Phoenix, AZ 85016<br>602-830-3900 |

# QUICK REFERENCE CHART

| Information Needed: | Contact the following: |
|---|---|
| **Medical Plan Claims Administrator**<br>• Medical plan Claims Administration<br>• Level One post-service claim appeals (Level Two to the Board of Trustees)<br>• **24-Hour Health Information Line** allows you to talk with a registered nurse 24/7, plus you have access to a health information library with over 1,000 prerecorded topics<br>• **My Personal Champion:** Cigna's Personal champions are trained to deliver an intense level of service that will help covered employees and their covered dependents with information, personal care planning and guidance in navigating health care needs.<br>• **Chronic Condition Support** for Plan Participants with health conditions like asthma, diabetes, low back pain, depression/bipolar/anxiety, emphysema/chronic bronchitis/COPD, cardiac conditions, metabolic syndrome, peripheral artery disease and osteoarthritis<br>• **Healthy Babies Program** offering free educational materials and 24/7 access to maternity nurses for help, parenting guidance tips, etc.<br>• **Healthy Rewards Program** providing discounts on health and wellness services like weight management, fitness, tobacco cessation, vitamins, etc. | **CIGNA**<br>1-800-244-6224<br>www.cigna.com<br>CIGNA's chronic condition support: 1-855-246-1873 |
| **Utilization Management (UM) Program**<br>• Precertification<br>• Appeal of UM decisions<br>• Case Management | **CIGNA**<br>1-800-244-6224<br>www.cigna.com |

# QUICK REFERENCE CHART

| Information Needed: | Contact the following: |
|---|---|
| **Medical Network**<br>• Network Preferred (OAP) Providers. **The network is called the Open Access Plus or OAP network.**<br>• Free Online Directory of Network OAP Providers in the State of Arizona. With the OAP network you have access to CIGNA Medical Group facilities, CIGNA urgent care centers located in the Phoenix metro area and the LifeSOURCE Programs of Excellence locations for transplants.<br>• Download the **CIGNA app** to your smartphone for easy access to network providers | **CIGNA**<br>1-800-244-6224<br>Online Directory of OAP Network Providers: www.cigna.com. Then click on "Find a Doctor."<br>*Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price.* Note: If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.<br>**CAUTION:** Use of a **non**-OAP network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. (See definition of "balance billing" in the Definition Article of this document). **Your lowest out of pocket costs will occur when you use CIGNA Network OAP providers**. Note: Balance billing does not apply to emergency services in a non-network hospital or Independent Freestanding Emergency Department center, non-emergency services by non-network providers at network facilities, or air ambulance services. |
| **Prescription Drug Program**<br>**Prescription Benefit Manager (PBM)**<br>• Retail network pharmacy locations<br>• Mail Order (home delivery) service<br>• Specialty Care Drug Delivery Service<br>• Precertification of certain drugs | **CIGNA**<br>1-800-244-6224<br>www.cigna.com |

# QUICK REFERENCE CHART

| Information Needed: | Contact the following: |
|---|---|
| **Telehealth Doctor Visit (effective 9-1-17)**<br>• Web or smartphone-based consultation with a board-certified Physician (an electronic visit called an e-visit) including diagnosis and treatment of nonemergency medical issues.<br>• **Timely and Convenient:** Physicians are available 24/7/365, lets you receive care when you need it. Typical visit is about 10 minutes. **You pay $10/visit** using Paypal, American Express, Visa, MasterCard or Discover card. No need to travel to a doctor's office.<br>• The physician will review your medical history, diagnose the condition and can prescribe necessary medications. The physicians can diagnose non-emergency medical problems such as ear infection, colds, pink eye or sore throat, and recommend treatment. They can provide behavioral and mental health services. Physicians can call in necessary medication to your preferred pharmacy.<br>• All plan participants enrolled in the AZ Pipe Trades Medical Plan have access to the telehealth services, a convenient, lower cost alternative to a physician office visit, urgent care visit or non-emergency care in an emergency room. You can consult with a doctor over the phone or on-line video, day or night when your regular doctor is not available. You can use telehealth services when you're traveling, too.<br>• Telehealth doctors:<br>o Are U.S. board-certified in internal medicine, family practice, emergency medicine or pediatrics.<br>o Are U.S. residents and licensed in your state.<br>o Average 15 years of practice experience.<br>**Please note:** Due to certain state laws, telehealth services may not be available if you are physically located in the states of AR, ID or MO when you place your call. But, if you have a plan from one of these states and are outside of these states when you call, the telehealth program is available to you. Online doctors are not able to prescribe controlled substances or lifestyle drugs. | **CIGNA Telehealth Connection**<br>Covered plan participants may access the telehealth services from MDLIVE 24 hours a day, 365 days a year:<br>To use this electronic Doctor visit service you must register online and can set up your account to be web-based, phone-based or via the mobile app.<br>**Pre-register before you get sick so the telemedicine app is ready to use.**<br>Three ways to obtain telehealth services:<br>a) Through the web:<br>MDLIVE: MDLIVEforCigna.com<br>Phone: 888-726-3171<br>b) Download the MDLIVE for Cigna App to your smartphone or mobile device.<br>c) Log into myCigna.com. Select the Cigna Telehealth Connection, then select MDLIVE.<br>**Remember, in an Emergency, call 911.** |
| **Employee Assistance Program (EAP)**<br>• Up to 12 therapy or coaching sessions per person, per year.<br>• The EAP Program provides professional, confidential information, support, short-term counseling and referral (at no cost) to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage, family, work-related problems, substance abuse (alcohol and drug treatment), crisis intervention along with financial and legal problems. | **Lyra Health, Inc.**<br>Web: ualocal469mentalhealth.com<br>Email: care@lyrahealth.com<br>Phone: 877-969-2917 |

# QUICK REFERENCE CHART

| Information Needed: | Contact the following: |
|---|---|
| **Dental PPO Plan**<br>• Dental PPO and Premier Network provider directory<br>• Dental PPO Plus Premier Plan Claims (Claim Appeals managed by the Administrative Office) | **Delta Dental Plan of Arizona**<br>P. O. Box 43000 Phoenix, AZ 85080-3000 (general correspondence)<br>Phone: (602) 938-3131 or (800) 352-6132<br>www.deltadentalaz.com<br>• To find a dentist visit: https://www.deltadentalaz.com/forms/find-dentist/<br>• Download the Delta Dental Mobile App (free for Android and iOS.<br>• Sign up for Member Portal at https://www.memberportal.com to view benefits, eligibility, claims status, check average dental costs in your area or update your delivery preference for dental benefit statements (EOBs) and go paperless. |
| **HRA Administration** | Same as the Administrative Office noted in the first row of this chart. |
| **Vision Benefits** | Same as the Administrative Office noted in the first row of this chart. |
| **Life (Death) and Accidental Death and Dismemberment (AD&D) Insurance** | **Mutual of Omaha Insurance Company**<br>Send application for Life Insurance and AD&D benefits to the Administrative Office at their address above. |
| **Plan Administrator (Board of Trustees)**<br>• Claim Appeals | **Board of Trustees for the Arizona Pipe Trades Health and Welfare Trust Fund**<br>3109 N. 24th Street, Suite 105<br>Phoenix, AZ 85016<br>Phone: 602-956-1950<br>Toll Free Phone: 1-877-429-7473 |
| **Privacy Officer and Security Officer** | **Board of Trustees for the Arizona Pipe Trades Health and Welfare Trust Fund**<br>**c/o BeneSys**<br>3109 N. 24th Street, Suite 105<br>Phoenix, AZ 85016<br>Phone: 602-956-1950<br>Toll Free Phone: 1-877-429-7473<br>www.azpipe.org |
| **COBRA Administrator** | Same as the Administrative Office noted in first row of this chart. |

# SUMMARY PLAN DESCRIPTION (SPD)

**FOR ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES**
**OF THE**
**ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND**

The following pages of this document comprise the Summary Plan Description (SPD). The Summary Plan Description provides an overview (highlights and summary) about the eligibility and benefits of the Plan in simplified language, including information on COBRA Coverage. Following the Summary Plan Description section of this document is the Plan's Rules and Regulations. The Rules and Regulations contain Articles that described in more detail the eligibility and benefits for Plan Participants in the Arizona Pipe Trades Health and Welfare Trust Fund.

The SPD is not intended to provide full details or interpret Plan provisions or to extend or change in any way the provisions of the Plan Rules and Regulations or the service agreements or insurance contracts. Any reference to an Article in the SPD can be found in the Rules and Regulations section of this document.

The provisions of the Plan are subject to and controlled by the Rules and Regulations. In the event of a conflict between the Summary Plan Description and the provisions of the Rules and Regulations, the provisions of the Rules and Regulations will prevail.

The Rules and Regulations are the ruling document for the self-funded plan eligibility and benefits. When there is an insured benefit, the documents produced by the various insurance companies are the ruling documents for the insured benefits of the Plan.

# SUMMARY OF BENEFITS

This Summary of Benefits outlines some of the key provisions of this Plan, but you should refer to the specific Article, Part, Section and Subsection of the Rules and Regulations Section of this document for a complete description of benefits and limitations. These schedules are subject to all the provisions of the Plan. Except for the Death Benefit and Accidental Death and Dismemberment Benefit, the amounts referred to in the summary are payable for non-occupational accidents and illness only.

## LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS FOR EMPLOYEES

The Life and Accidental Death and Dismemberment benefits are underwritten by a Life Insurance Company. To file a claim, send written proof of the loss within 30 days of the date of the loss to the Administrative Office which will coordinate administration of this benefit with the Life Insurance Company. The Administrative Office will then mail you or your designated Beneficiary (for Death benefits) a claim form to be completed. When the proof of loss has been approved, a benefit check will be sent to you (for AD&D benefits) or your designated Beneficiary (for Death benefits).

| **Schedule of Benefits for Life and Accidental Death and Dismemberment (AD&D)**<br>This is a brief overview. For more complete information on these benefits refer to the certificate of insurance available from the Life Insurance Company whose name is listed on the Quick Reference Chart in the front of this document. | |
|---|---|
| **Life Insurance (Death Benefit)** | Effective on the later of June 1, 2001, or the day the Eligible Employee becomes eligible under the Plan:<br>• **Employee's Death:** $50,000 (paid to your designated Beneficiary)<br>• **Spouse's Death**: $1,000<br>• **Child's Death**:<br>  • Age less than 14 days: none<br>  • Age 14 days but less than 6 months: $100<br>  • Age 6 months but less than 26 years: $500 |
| **Accidental Death and Dismemberment (AD&D) (Active Employees Only)** | • $50,000 for losses of life<br>• $20,000 for loss of both hands, both feet, or both eyes<br>• $10,000 for loss of one hand, one foot or sight of one eye<br>• $5,000 for loss of thumb and index finger of same hand |

## WEEKLY DISABILITY BENEFIT FOR ACTIVE EMPLOYEES AND COBRA SELF-PAY EMPLOYEES

Weekly Disability benefits are available to Eligible Active Employees (and Active Employee eligible for Weekly Disability benefits also includes a COBRA self-pay Employee) who become totally and continuously disabled from a non-occupational illness or injury that occurs while eligible for this benefit. Contact the Administrative Office if you have questions about this benefit.

| **Schedule of Weekly Disability Benefits**<br>This is a brief overview. For more complete information on these benefits refer to Article III. | |
|---|---|
| **Weekly Benefit** | $500 per week |
| **Duration of Disability Benefit** | Up to 26 weeks |
| **When Payment Begins** | Payment begins with the 1st day of disability due to an accident; on the 8th day of disability due to sickness (however, for a sickness for which the Eligible Active Employee is absent from work for more than 7 days, payment will be made from the 1st day of the absence) |

## COMPREHENSIVE MEDICAL PLAN BENEFITS FOR EMPLOYEES AND DEPENDENTS

Article XV contains the information about the Medical Plan (using the CIGNA OAP Provider network) including a Benefit Highlights chart and information on outpatient prescription drug benefits along with requirements for pre-admission certification. Contact the Medical Plan Claims Administrator or the Administrative Office if you have questions about Medical Plan benefits.

**Medical Network:** As part of the Medical Plan, the Fund contracts with an independent Medical Network that is comprised of Physicians, laboratories, Hospitals and other Health Care Practitioners. Use of the providers that are under contract to the network saves both you and the Fund money by the discounts offered by these providers. The Physicians, Health Care Facilities and other providers who are members of the network are outlined in a Network Provider Directory available online from the Medical Plan OAP Network.

Access to the OAP directory is free and available by contacting the Medical Plan Network as noted on the Quick Reference Chart in the front of this document.

Medical Plan Network providers are also sometimes referred to as Open Access Plus or OAP providers, Network providers, contracted providers or simply network providers.

Under the Medical Plan as explained in Article XV, Eligible Individuals are covered for expenses incurred for most, but not all, medical services and supplies. The medical expenses for which you are covered are limited to those that are:

1. Determined by the Medical Plan Claims Administrator to be "**Medically Necessary**," and paid in accordance with the "**Maximum Reimbursable Charge**;" and
2. **Not services or supplies that are excluded** from Medical Plan coverage; and
3. **Not services or supplies in excess** of a Maximum Plan Benefit; and
4. **Are for the diagnosis or treatment of an injury or illness** (except where wellness/preventive services are payable by the Medical Plan.

Generally, **the Plan will not reimburse you for all medical expenses submitted**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance or Copayments toward the amounts you incur that are eligible medical expenses.

## SCHEDULE OF DENTAL PPO PLAN BENEFITS

Note: While Dental services may be obtained from any licensed dental care provider, the Fund has entered into an agreement with an independent **Dental PPO Network** whose name and phone number is listed on the Quick Reference Chart in the front of this document. This Dental PPO Network contracts with Dentists who are located in Arizona. Under the network arrangement, contracted Dental PPO Network providers charge a cost that is **significantly less** than their regular fees (a discounted fee).

While you do not have to use a Dental PPO Network provider, using Dental PPO Network providers will save you and our Fund money. This is because you will pay your Participant Coinsurance based on the discounted amount rather than on the non-discounted amount (called the Allowed charge).

Out-of-Network providers do not offer discounted fees to you or the Fund and they can also bill you for any balance that is due in addition to the amount that was payable by the Plan (called "Balance Billing"). Dental PPO Network providers are prohibited (by their contract with Delta Dental) from billing you for differences between their normal fees and the amount that is considered allowable by this Plan.

| | | |
|---|---|---|
| **Deductible for the Dental Plan** | $25 per person per Calendar Year<br>$50 per family per Calendar Year<br>The Dental Deductible will be waived for Preventive dental services described in Article VI of this document. | |
| **Annual Dental Benefit Maximum** | $3,000 per person per Calendar Year | |
| | **Dental PPO and Premier Network Providers** | **Out-of-Network Providers** |
| **Coinsurance for Dental Services** | *No charge, no deductible for preventive dental services*<br>*All other covered dental services:*<br>80% of the network discounted amount is paid by the Plan<br>and<br>20% of the network discounted amount is paid by the Participant | *No charge, no deductible for preventive dental services*<br>80% of the Allowed charge is paid by the Plan and 20% of the Allowed charge is paid by the Participant, plus you could be billed for the difference between the provider's billed charges and the Plan's Allowed Charge amount (referred to as balance billing) |
| | **Reminder:**<br>**Using Dental PPO Network providers will save YOU and our Fund money.** | |
| **Orthodontia** | No coverage | |

| SCHEDULE OF VISION PLAN BENEFITS<br>This chart shows what the Plan pays. See the Rules and Regulations in this document for more detailed information. Contact the Administrative Office if you have benefits questions. | | |
|---|---|---|
| **Benefit Description** | **Explanation and Limitations** | **What the Plan Pays** |
| **Vision Benefits for the Active Employee and his/her eligible Dependents**<br>• Services are available from an ophthalmologist or an optometrist. There is no vision network.<br>• Covered vision benefits include:<br>  • Eye examinations, no more than once within a Calendar Year period.<br>  • Lenses, no more than once within a Calendar Year period.<br>  • Frames, no more than once within a Calendar Year period.<br>  • Contact lenses, no more than once within a Calendar Year period or one year supply of disposable contacts to the benefit maximum.<br>  • Prescription safety glasses and goggles for Active Employees only. This benefit allows up to an additional $200/Active Employee every 24 months toward frames, lenses and add-ons for prescription safety glasses and goggles; and<br>  • Prescription sunglasses. | • When vision services are elected, covered vision benefits (eye exam and vision supplies) are payable to a maximum of $300 per person per Calendar Year, no deductible applies.<br>• No benefits are payable for:<br>  • Non-prescription sunglasses.<br>  • Safety glasses or goggles (except that prescribed safety glasses or goggles will be covered for Active Employees only instead of glasses or contacts.)<br>  • Medical or surgical treatment of eyes which would normally be covered under the Medical Plan.<br>  • Services or materials provided as a result of any Workers' Compensation law, or similar legislation, or obtained through or required by a government agency or program whether Federal, State or any subdivision thereof.<br>  • Expenses for which payment is made under any other benefit provided by the Plan other than this vision benefit.<br>  • Orthoptics (vision training to improve the visual perception and coordination of the two eyes), subnormal vision aids and any associated supplemental testing.<br>  • Glasses secured when there is no prescription issued by an ophthalmologist or optometrist, such as reading glasses obtained from a drugstore. | For vision services, the Plan pays 80% of Charges, no Deductible applies, up to $300 per person per Calendar Year. |

| SCHEDULE OF VISION PLAN BENEFITS<br>This chart shows what the Plan pays. See the Rules and Regulations in this document for more detailed information. Contact the Administrative Office if you have benefits questions. | | |
|---|---|---|
| **Benefit Description** | **Explanation and Limitations** | **What the Plan Pays** |
| **Vision and/or Dental Benefits for the eligible Early Retiree and his/her Spouse**<br>• Expenses associated with any Vision and/or Dental care (as described in this row).<br>• There is no vision network.<br>• To be reimbursed for Vision and/or Dental benefits, send the bill or receipt along with the following information to the Administrative Office within 2 years of receiving the care:<br>  ◦ The date service(s) were received;<br>  ◦ The type and cost of service(s) you received; and<br>  ◦ The date you paid the provider for the service(s) you received. | • The Vision and/or Dental benefits are **not** available to Dependent Children.<br>• The Vision and/or Dental benefits are **not** available to Early Retirees who are under age 55 on the date of their retirement or their Spouse.<br>• Expenses associated with any Vision and/or Dental care are payable to a combined **maximum of $300** per person per Calendar Year. | Plan pays: 100%, no Deductible applies, up to a combined maximum of $300 per person per Calendar Year. |

# HOW TO FILE A CLAIM

### For Death Benefits:

Whenever there is a death claim, a claim form should be obtained from the Administrative Office. The completed form should be returned to the Administrative Office with a certified copy of the death certificate, along with the deceased's Social Security number. The benefit check will be forwarded to your Beneficiary upon processing by the insurance company.

### For Weekly Disability benefits:

To file a request for disability benefits, obtain a Weekly Disability Statement Of Claim form from the Administrative Office or from the Fund's website at www.azpipe.org.

### For Dental PPO Plan and Vision Benefits:

Most dental and vision providers will send their bill directly to the Plan in care of the Administrative Office. However, for those providers who do not bill the Plan directly, you may be sent a bill. In that case, you will need to submit the bill to the Administrative Office.

**For Medical Plan** claims filing and the time limit for claims submission to the Plan, see the information in Article XV.

For information on how to file a claim for **HRA benefits**, see Article V.

**Time Limit for Claims Submission to the Plan:** All eligible claims must be submitted to the Administrative Office within the timeframe noted in the box below.

**TIME LIMIT FOR FILING DENTAL PPO PLAN, VISION PLAN, HRA, AND WEEKLY DISABILITY CLAIMS**

- All post-service dental and vision claims must be submitted to the Plan within TWO YEARS from the date of service.
- HRA claims for reimbursement must be submitted to the Plan within TWO YEARS from the date of service.
- Weekly disability claims must be submitted to the Plan within TWO YEARS from the date of onset of the disability.

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

### Keep Your Records:

It is necessary to keep separate records of expenses with respect to each of your Dependents as well as yourself because the provisions of the Plan operate separately for each covered family member. The following data is important and you should keep a copy yourself and send a copy with your claim:

1. The name and address of your Physician, Health Care Practitioner, Surgeon or Dentist;
2. The date you incurred each expense; and
3. Copies of all itemized statements, such as bills from Physicians, Hospitals, laboratories and Out-of-Network retail pharmacies. A bill from an Out-of-Network retail pharmacy should always give the date of the purchase, prescription number, name of the drug or supply, and name of the Physician or Health Care Practitioner who issued the prescription. Each of these statements should indicate clearly the name of the member of your family involved.

### Procedure to Request Enrollment and Beneficiary Designation Forms:

It is important that the Administrative Office have a completed and current enrollment form for you in the files. You must have completed an enrollment form before claims can be processed. If you have not completed an enrollment form, obtain one from your Local Union Office or from the Administrative Office or the website at www.azpipe.org immediately, and send it to the Administrative Office. You and your Spouse, if an enrolled covered Dependent, must send the Administrative Office a new enrollment form in the event that:

1. You change your home address.
2. You wish to add or change your Beneficiary.
3. There is any change in your family status by reason of marriage, birth of a child, adoption or placement for adoption, loss of other coverage, death, divorce or legal separation.

The failure to promptly report any changes affecting eligibility will subject you (and may subject your Spouse) to repaying amounts that were paid on behalf of a person rendered ineligible by the changed circumstance.

Remember that the Administrative Office and Cigna must have this enrollment form in order to take care of your claims.

### If You Need Assistance:

If at any time you have questions concerning eligibility or benefits, please do not hesitate to write or call the Administrative Office. They will promptly advise you of the answers to your questions. The name and address and phone number to the Administrative Office is listed on the Quick Reference Chart in the front of this document.

## ELIGIBILITY INFORMATION

**No Medical Examination:** All Eligible Employees and their Dependents will be covered without a medical examination.

The term **"Employee,"** as used in the Eligibility provisions, means a person on whose behalf his/her employer makes contributions to the Fund because the employer is bound to the Working Agreement between the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, Local Union No. 469 and the Arizona Mechanical Contractors Association (Working Agreement); another collective bargaining agreement approved by the Trustees, or by operation of law. The term Employee also includes the following groups when contributions are received on their behalf:

1. Corporate officers of signatory employers to the Working Agreement, provided such employers have executed a participation agreement for all corporate officer Participants;
2. A regularly employed and salaried officer, business representative and organizer of the Union;
3. An apprenticeship coordinator or assistant apprenticeship coordinator regularly employed by any apprenticeship committee established by the Working Agreement;
4. Those individuals eligible under non-job site participation rules;
5. Individuals working outside of Arizona on whose behalf employer contributions are paid to the Fund by virtue of a reciprocity agreement.

**Eligibility:**

**For Active employees (including non-bargaining alumni) eligible as of October 2006, eligibility for the benefits provided by the Health and Welfare Plan is earned under the "Hour Bank Plan."** The Hour Bank Plan is a system under which an Active Employee's hours worked for a contributing employer are accumulated for credit in an Hour Bank account, much in the same manner as funds are accumulated in a savings account. Under this Plan, it is possible to accumulate as much as:

1. Up to 1,120 hours (eight months of paid-up eligibility with a 140 hours per month charge off) for hours worked prior to November 1, 2016, for Employees who have contributions made on their behalf at the rate established in the Working Agreements for Building Trades Journeyman rate (not including the Retiree Health Reimbursement Account (HRA) contribution);
2. Up to 700 hours (five months of paid-up eligibility with a 140 hours per month charge off) beginning with hours worked on or after November 1, 2016, for Employees who have contributions made on their behalf at the rate established in the Working Agreements for Building Trades Journeyman rate (not including the Retiree Health Reimbursement Account (HRA) contribution). Effective January 1, 2023, through June 30, 2025, "hours worked" shall include actual hours, not to exceed 40 hours in any week, that an Indentured Apprentice attended the day-time training program administered by the Arizona Pipe Trades Joint Apprenticeship Committee.
3. Employees whose Hour Banks exceeded 700 hours as of November 1, 2016, will not forfeit those excess hours, but will be subject to the new 700-hour bank maximum once the Employee's hour bank is less than the new 700-hour maximum.
4. Up to 450 hours (three months of paid-up eligibility with a 150 hours per month charge off) for Employees who have contributions made on their behalf at less than the rate established in the Working Agreements for Building Trades Journeyman rate (not including the Retiree Health Reimbursement Account (HRA) contribution).

**Non-bargaining non-alumni employees** who first became eligible after 2006 do not have hour bank eligibility and instead, eligibility is determined on a month to month basis based on receipt of employer required contributions.

**Lag Month:**

In order that there will be sufficient time for employers reports to be received and processed by the Administrative Office, a "lag month" will be used in determining your monthly eligibility. The lag month is the month between the payroll period and the month of actual coverage. See also Article II on Eligibility.

**Dependent:**

The term "Dependent" is defined in Article I on General Definitions.

**Newborn:** With respect to Medical Expense Benefits, newborn Dependent Children are covered from birth, including coverage for medically diagnosed congenital defects and birth abnormalities for a newborn child. Routine nursery care is covered in connection with bodily injury and sickness, including medically diagnosed congenital defects or birth abnormalities.

**Adult Disabled Child:** If your covered Dependent Child is incapable of self-sustaining employment because of mental retardation or physical disability on the date the Dependent's coverage would otherwise terminate on account of age, and if within 31 days of that date you submit to the Administrative Office satisfactory proof of incapacity, the Dependent will retain eligibility for Medical Expense Benefits during the period of his/her incapacity. The Fund may subsequently require proof of the Dependent's incapacity as specified in the Rules and Regulations. This extension will continue until the earliest of (1) the last day of the month in which the individual ceases to be eligible for reasons other than age, (2) the last

day of the month in which the individual ceases to be incapacitated, or (3) 31 days after the Administrative Office requests additional proof of incapacity if you fail to furnish such proof.

**Special Notice on Effective Date:** The effective date of coverage for any Employee (or Dependent) shall be the date on which the individual qualifies for coverage in accordance with the above rules.

Employees and Retirees must enroll their Dependents in order for those Dependents to be eligible for benefits under the Plan. No payments are to be made for days of Hospitalization which occurred prior to the effective date or for medical or surgical services rendered prior to that effective date.

**Continuation of Eligibility:**

Hours worked for contributing employers by each Employee will be credited to the individual's Hour Bank. Hours of work credit will be deducted from each Employee's Hour Bank for each month of coverage at the rate of 150 hours per month for the first 24 continuous months of eligibility and 140 hours per month thereafter, and Employees will continue to remain covered as long as their Hour Bank contains sufficient hours of work credit for the current month's coverage.

Whenever an Employee works more than the number of hours required for a month of coverage (150 or 140 hours), then such excess hours will be added to the Employee's Hour Bank accumulation. In this circumstance, Employees will be allowed to accumulate excess hours in their Hour Bank up to a maximum of 700 hours, as explained in the Eligibility provisions described earlier in this chapter.

In accordance with the **Family and Medical Leave Act of 1993 (FMLA)**, qualified Employees are entitled to 12 weeks (in some cases up to 26 weeks) of unpaid leave and can continue to maintain coverage under this Plan for the duration of the leave. Qualifications for this provision are outlined in the Act and subsequent regulations and your employer should also be able to provide some additional information about FMLA.

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

In accordance with the **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**, qualified individuals are entitled to 24 months of unpaid leave in the event they are called to active military service for a period exceeding 31 days, and can continue to maintain coverage under this Plan during the related active military service. Qualifications for this provision are outlined in the Act and subsequent regulations.

Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible Dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Additionally, the employee (and any eligible Dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected, (both cannot be elected by the same person). Contact the Administrative Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

**Termination of Benefits:**

An Employee's coverage will terminate at the end of the month in which the work credits in his/her Hour Bank fall below 150 hours, after the deduction of 150 hours for the current month's coverage if the Employee has been eligible for less than 24 continuous months, or 140 hours, after deduction of 140 hours for the current month's coverage if the Employee has been eligible for 24 or more continuous months.

An Employee's Hour Bank accumulation and rights to the reduced self-payment rate (Option 1 below) will be canceled and coverage will be terminated on the last day of the month in which an Employee engages in any of the following situations:

1. If the Employee takes employment in Arizona in any capacity or continues employment in Arizona in any capacity with any employer NOT obligated to contribute to the Arizona Pipe Trades Health and Welfare Trust Fund.

2. If the Employee engages in any kind of commercial business activity in Arizona as a sole proprietor, partner, contractor or commission agent without being a signatory to a labor agreement with Local Union 469 requiring contributions to the Arizona Pipe Trades Health and Welfare Trust Fund.

**NOTE:** For purposes of the two foregoing paragraphs, work on a part-time or temporary full-time basis, other than at the trade or in the plumbing, pipefitting and refrigeration industry, shall not cause the automatic forfeiture and cancellation, PROVIDED the person performing such work continues to evidence desire to continue work for contributing employers by maintaining registration at the hiring hall of Local 469.

In the event of termination, you and your eligible Dependents may have the right to participate under the "Self-Payment Provision." This right to participate under the Plan's self-payment provision does not apply to individuals who are working for an employer who has stopped contributing to the Fund. This provision allows you to continue to be covered up to a maximum of 18 months (36 months for certain Dependents) by contributing to the cost of your coverage on a self-payment basis as described in the "Self-Payment Provision" Section.

**Employees in the Armed Forces:** The eligibility of Employees who enter full-time active duty with the Armed Forces (and Dependents, if any) is to be terminated on the date of entrance upon such active duty, except as specified in the Article II on Eligibility.

**Reinstatement of Eligibility:** An Employee whose eligibility has terminated shall again become covered if his/her Hour Bank shows a total of at least 140 hours (150 hours if the Employee has been continuously eligible for less than 24 months) within the two-year period subsequent to the termination of coverage. Such reinstatement shall be effective on the first day of the second month that follows the month in which this requirement is met. If the Employee is not reinstated, his/her account shall be forfeited. Such an Employee shall again become eligible for coverage upon completion of the eligibility requirement as set forth in the "Eligibility" Section.

**Dependents**: The coverage on Dependents will cease automatically (1) on the date of termination of your coverage; or (2) on the date the Dependent ceases to be a Dependent as defined under this Plan.

# SELF-PAYMENT PROVISIONS AND COBRA INFORMATION

**Active Employees Self-Payment:**

If an Active Employee loses eligibility under the Hour Bank provisions because of the termination or reduction in hours of employment, eligibility may be continued by making self-payments payable to the Fund and sending them directly to the Administrative Office. If such insufficiency is due to retirement and the Employee qualifies under the Section titled "Early Retiree Self-Payment Option," the Employee may choose between coverage under this "Active Employees Self-Payment" provision or coverage under the "Early Retiree Self-Payment" program option.

**NOTICE:** The Administrative Office will notify an Active Employee who has lost eligibility under the Hour Bank provisions. The affected persons will have until the **later of** 60 days from the date of such notice, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making self-payments.

**Coverage Available - Self-Payment Premium:** An Active Employee electing to continue eligibility for himself or herself and/or his/her eligible Dependents on a self-payment basis can choose between the two options discussed below, depending upon their eligibility for those options:

**OPTION 1: NON-COBRA REDUCED SELF-PAYMENT**

An Active Employee electing to continue eligibility for himself or herself and his/her eligible Dependents on a self-payment basis **can continue Medical Plan benefits and Weekly Disability benefits only**. Any Participant who has been continuously eligible for health and welfare benefits for 36 months out of the last 42 consecutive months may continue coverage under this option **for up to 12 months** at a reduced self-payment rate.

Reduced self-payment rates are not available to Participants whose coverage has been terminated as a result of engaging in prohibited employment as outlined in the paragraphs numbered 1 and 2 of the "Termination of Benefits" Section noted above.

After 12 months on Option 1, the individual can elect to continue Medical Plan and Weekly Disability benefits for up to six more months and can now choose to add Dental PPO Plan and/or Vision benefits. There is no coverage available under Option 1 after a total of 18 months of Medical Plan coverage unless the individual is disabled.

**OPTION 2: COBRA SELF-PAYMENT**

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group health plans offer Employees and their covered Dependents the opportunity to **temporarily** continue their health care coverage (medical, dental and vision) at group rates when coverage under the Plan would otherwise end. An Active Employee electing to continue eligibility for himself or herself and the Employee's eligible Dependents on a COBRA self-payment basis can choose to continue Medical Plan, Dental PPO Plan, Weekly Disability, and Vision benefits.

The amount of the self-payment premiums for each option will be established by the Board of Trustees, and is subject to change at their discretion, but not more often than once every 12 months.

- Note that for a COBRA Qualified Beneficiary who elected Medical Plan, Dental PPO Plan, Weekly Disability, and Vision benefits and who is no longer eligible to participate in COBRA's Medical Plan coverage because of the Qualified Beneficiary's entitlement to Medicare, the Plan will permit the COBRA Qualified Beneficiary to continue to self-pay his/her COBRA premium to continue coverage under the Dental PPO Plan and Vision benefits for the remainder of the months of COBRA coverage.

**Other Health Coverage Alternatives to COBRA:** Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

**COBRA Administrator**: The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

**NOTE:** This Option 2 Section serves as a notice to summarize your rights and obligations under the COBRA Coverage law. It is provided to all Active Employees (and also applies to Early Retirees) and their covered Spouses and is intended to inform them (and their covered Dependents, if any) in a summary fashion of their rights and obligations under the continuation provisions of the federal law. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this information carefully and be familiar with its contents.

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

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

Qualified Beneficiaries who elect COBRA Coverage must pay for it at their own expense. This Plan provides no greater COBRA rights than what is required by law and nothing in this provision is intended to expand a person's COBRA rights.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Active Employee or the Spouse or Dependent Child of an Active Employee who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the Qualified Beneficiary during a period of COBRA Coverage is also a Qualified Beneficiary. A person who becomes the new Spouse of an existing COBRA Participant during a period of COBRA Coverage is not a Qualified Beneficiary.

    - A child of the covered Active Employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO) during the Active Employee's period of employment, is entitled to the same rights under COBRA as an eligible Dependent Child.

    - A person who becomes the new Spouse of an existing COBRA Participant during a period of COBRA Coverage may be added to the COBRA coverage of the existing COBRA Participant but is not a "Qualified Beneficiary." This means that if the existing COBRA Participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for himself/herself.

2. **"Qualifying Event"**: Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but does not lose his/her health care coverage under this Plan, (*e. g.*, Employee continues working even though entitled to Medicare) then COBRA is not available.

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

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

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

**Note: Working for an employer who is not required to make contributions to the Plan is not a Qualifying Event under this Plan.**

**Special Enrollment Rights**

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

**Maximum Period of COBRA Coverage**

The maximum period of COBRA Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Coverage may be extended for up to 11 months under certain circumstances (described in another Section of this provision on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the Section on "Maximum Period of COBRA Self-Payments" that appears later in this Section.

**Medicare Entitlement**

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

**IMPORTANT NOTE: If you are disabled, be sure that you take the appropriate steps to apply for Medicare Part A and B by contacting your local Social Security Office.**

**Procedure on When the Plan Must Be Notified of a Qualifying Event (Very Important Information)**

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

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

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

Officials of the Employee's own employer should notify the COBRA Administrator of an Employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

**Notices Related to COBRA Coverage**

When:

1. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or
2. **<u>you</u> fulfill your obligation to notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

**then** the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Coverage.

<u>Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage and will subject you (and may subject your Spouse) to repaying amounts that were paid on behalf of a person rendered ineligible by the changed circumstance</u>.

Under the law, you and/or your covered Dependents will have only **60 days** from the date of receipt of that notice, to elect COBRA Coverage.

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

**The COBRA Coverage That Will Be Provided**

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

**Paying for COBRA Coverage (The Cost of COBRA)**

By law, any person who elects COBRA Coverage must pay the full cost of the COBRA Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated Active Employees and their families (including both the Fund's and Employee's share), plus an additional 2%. If the 18-month period of COBRA Coverage is extended because of disability, the Plan may add an additional 50% to the cost of coverage for similarly situated Active employees and their families (but only if the disabled person is covered) during the 11-month additional COBRA period.

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

**NOTE: You will not receive an invoice (bill) for the initial COBRA premium payment(s).** For subsequent months, you will receive a receipt/COBRA premium notice; however, not receiving a receipt/premium notice will not extend the due date of your COBRA premium payment. You are responsible for making timely payments for COBRA Coverage to the COBRA Administrator listed on the Quick Reference Chart.

**IMPORTANT**

**You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator – not receiving a receipt/premium notice will not extend the due date of your payment.**

**The Trade Act**

The Trade Adjustment Assistance Reform Act of 2002 (also called the Trade Act or TAA Program) creates a variety of benefits and services including a health coverage tax credit (HCTC) for certain individuals who have become eligible for Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA), and for certain retired Employees receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (called Eligible Individuals).

The health coverage tax credit is designed to help reduce the Out-of-Pocket cost of COBRA coverage for individuals who have become unemployed as a result of increased imports from, or shifts in production to, foreign countries. Because the HCTC is authorized under federal law, the rules for program eligibility are subject to change. If this provisions conflicts with current federal law, then that law will apply.

- HCTC Eligible Individuals can either take a tax credit or get help paying their premiums as they become due.
- If you have questions about these rules contact: the United States Department of Labor Employment and Training Administration, the Division of Trade Adjustment Assistance at phone: 1-888-365-6822 or website: http://www.doleta.gov/tradeact or the HCTC website: http://www.irs.gov/individuals/article/0,,id=187948,00.html.

**Grace Periods**

The initial payment for the COBRA Coverage is due to the COBRA Administrator **no later than 45 days** after the date you elect COBRA Coverage. If this payment is not made when due, COBRA Coverage will not take effect.

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

**For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?**

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

If there is a significant shortfall, then COBRA continuation coverage will end.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred. If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the end of the month in which the last full COBRA premium payment was made.

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

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

**Addition of Newly Acquired Dependents**

If, while you (the Employee) are enrolled for COBRA Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a

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

**Loss of Other Group Health Plan Coverage**

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

The loss of coverage must be due to exhaustion of COBRA Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or Participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or Dependent Child within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Coverage.

**Notice of Unavailability of COBRA Coverage**

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

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

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

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

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

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

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

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

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

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

months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

**IMPORTANT NOTE: If you are disabled, at your earliest convenience, be sure that you take the appropriate steps to apply for Medicare Part A and B by contacting your local Social Security Office.**

1. This extension is available only if:

   - The Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**

   - The disability lasts until at least the end of the 18-month period of COBRA Coverage.

   **Notifying the Plan**: You or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, email, or fax, or be hand-delivered, and is to include your name, the disabled person' name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.

1. The cost of COBRA Coverage during the additional 11-month period of COBRA Coverage will be higher than the cost for that coverage during the 18-month period.

2. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

**Notice of Early Termination of COBRA Coverage**

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, and the date COBRA coverage terminated. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

**Maximum Period of COBRA Self-Payments (Early Termination of COBRA)**

Once COBRA Coverage has been elected, it may be cut short (terminated early) on the occurrence of certain events, explained here. The right of an Active Employee and/or eligible Dependents to make COBRA self-payments shall be continued until the end of the month in which the earliest of the following events occurs:

1. Coverage ceases by reason of the failure of the Qualified Beneficiary to make timely COBRA self-payments (in full) required by the Board of Trustees.

2. The Qualified Beneficiary first becomes, after the date of election of COBRA, entitled to Medicare.

3. The Qualified Beneficiary first becomes, after the date of election, covered under any group health plan, including this Plan. **NOTE:** If the other plan contains limitations or exclusions for any pre-existing conditions, any individual so limited or excluded by the other plan may continue coverage until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Section.

4. During an extension of the maximum coverage period to 29 months due to the disability of the Covered Person, the disabled person is determined by the Social Security Administration to **no longer be disabled**.

5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA Participants under the Plan as described in Article II on Eligibility).

6. The Fund ceases providing any benefits to any Participant.

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

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

**COBRA Questions or To Give Notice of Changes in Your Circumstances:**

If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Coverage, you must notify the COBRA Administrator:

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

**Early Retiree Self-Payment Option:** (For Early Retirees who are receiving a pension award from the Arizona Pipe Trades Pension Trust Fund.)

An Early Retiree who has been eligible for Fund benefits for at least 36 months out of the prior 42 consecutive months (not to include more than six months COBRA self-pay Option 2) immediately preceding the first month the individual receives a pension award from the Arizona Pipe Trades Pension Trust Fund and who is not entitled to Medicare, can continue Medical Plan benefits only if the individual so elects, upon timely payment of the proper self-payment rate, as determined by the Board, to the Administrative Office.

Notwithstanding the previous paragraph, an individual who receives a pension award from the Arizona Pipe Trades Pension Trust Fund may also participate in the Medical Plan provided the individual was continuously eligible for benefits for a minimum of 25 years under the Arizona Pipe Trades Health and Welfare Trust Fund. Such person must make application to the Board of Trustees.

**IMPORTANT NOTE:**

THE ELECTION TO PARTICIPATE IN THE MEDICAL PLAN MUST BE MADE AT THE TIME THE INDIVIDUAL FIRST RECEIVES A PENSION AWARD FROM THE ARIZONA PIPE TRADES PENSION TRUST FUND OR ON THE DATE FOLLOWING THE PENSION AWARD IN WHICH THE INDIVIDUAL EXHAUSTS HIS/HER HOUR BANK.

IF THE INDIVIDUAL RETURNS TO WORK AND ESTABLISHES ELIGIBILITY AS AN ACTIVE EMPLOYEE AND THEN LOSES THAT ELIGIBILITY, HE MAY RESUME PARTICIPATION IN THIS PLAN AS AN EARLY RETIREE, UPON PAYMENT OF APPROPRIATE SELF-PAYMENTS, SO LONG AS HE MAINTAINS CONTINUOUS ELIGIBILITY.

AN INDIVIDUAL WHO QUALIFIES UNDER THE 25 CONSECUTIVE YEAR REQUIREMENT (OR HIS/HER SPOUSE) MAY DEFER THE ELECTION TO PARTICIPATE IN THE MEDICAL PLAN PROVIDED THE PERSON RETAINS CONTINUOUS COMPARABLE COVERAGE UP TO THE DATE OF PARTICIPATION IN THE MEDICAL PLAN.

Continuation of the benefits described in this Subsection applies to the Self-Payment Employee and/or the eligible Dependents. Payments can be continued until the earliest of the following events occurs:

1. The Fund ceases providing Early Retiree benefits.
2. The Fund ceases providing any benefits to any Participant.
3. Coverage ceases by reason of the failure of the Early Retiree to make timely self-payments (in full) required by the Board of Trustees.
4. The Early Retiree and/or eligible Dependents first becomes, after the date of election, entitled to Medicare. (NOTE: You should be enrolled under Medicare Part A and B and/or C in order to receive the maximum amount of benefit. The Arizona Pipe Trades Plan will no longer be your primary insurance once you and/or your Dependents become entitled to Medicare. This is whether you choose Medicare or not.)

**Dependent COBRA Self-Payments:**

If any Dependent(s) lose(s) coverage for the benefits of this Fund because of:

1. The death of an Active Employee or Self-Payment Employee;
2. The divorce of an eligible Active Employee or Self-Payment Employee;

3. The attainment of Medicare entitlement by any Self-Payment Employee; or

4. In the case of a Dependent Child, ceasing to meet the definition of Dependent under the Plan;

they may continue by making COBRA self-payments payable to the Fund and sent directly to the Administrative Office.

**NOTE:** Dependents whose coverage under this Plan is affected by death, divorce, Medicare entitlement or a Dependent Child ceasing to meet the definition of Dependent under the Plan are responsible for notifying the Administrative Office of those facts within 60 days of the affecting event. The Administrative Office will then notify the Dependents of their rights under these provisions within 14 days. The Dependents will have until the **later of** 60 days from the date of the notice from the Administrative Office, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making COBRA self-payments.

**COBRA Self-Payment Premium for Dependents:**

The amount of the monthly COBRA self-payment premiums for Dependents will be established by the Board of Trustees. The self-payments charged represent continuation of all health-related benefits provided for those Dependents as of the date the Dependents would have otherwise lost eligibility, or, if the Dependents so elect, **only** Medical Plan benefits.

**NOTE:** A Dependent(s) who lose(s) coverage for the benefits of this Fund because of the death of an Active Employee or Self-Payment Employee (a COBRA Qualifying Event) will be entitled to a subsidized COBRA premium rate if the Active or Self-Payment Employee had been continuously eligible for health and welfare benefits for 36 months out of the last 42 consecutive months prior to the Qualifying Event.

Additionally, in the event of the death of an Active Employee or Self-Payment Employee who maintained a Health Reimbursement Account (HRA), the surviving Spouse and tax-qualified surviving Dependents may continue to submit eligible Medical Care Expenses to the deceased employee's HRA. See Article V: Health Reimbursement Arrangement (HRA) of this document for more details.

**Maximum Period of COBRA Self-Payments for Dependents:**

The right of Dependents to make self-payments shall be continued until the end of the month in which the **earliest** of the following events occur:

1. Coverage ceases by reason of the failure of the Dependents to make timely COBRA self-payments (in full) required by the Board of Trustees.

2. The Dependent first becomes, after the date of election, entitled to Medicare.

3. The Dependent first becomes, after the date of election, covered under any group health plan, including, without limitation, this Plan. **NOTE:** If the other plan contains limitations or exclusions for any pre-existing condition, any individual so limited or excluded by the other plan may continue coverage under this Plan until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Section.

4. 36 months have passed since the initial loss of eligibility under this Plan.

5. The Fund ceases providing any benefits to any Participant.

**Payment of Self-Payment Premium (Active Employees, Early Retirees and Dependents):**

The initial self-payment premium (retroactive to the date of loss of eligibility) must be paid no later than the 45th day after the date the Administrative Office is notified of the person's election to make self-payments. Each subsequent self-payment is due on the first day of the month for which coverage is intended. **Self-Payments received at the Administrative Office later than 30 days after the due date will not be accepted, and rights to self-payments will terminate.**

**Trustee Rights:**

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

**Persons Whose Eligibility is Affected by Multiple Events:**

Notwithstanding anything to the contrary herein, no person may enjoy any one continuous self-payment coverage extension under the Fund beyond 36 months from the end of the month in which the **first** event giving rise to self-payment

rights with respect to that person occurred. For these purposes, participation in the "Early Retiree Self-Payment Option" is not considered an event giving rise to self-payment rights.

## WORKERS' COMPENSATION

With the exception of Death and Accidental Death and Dismemberment benefits, all benefits provided under this Plan are for non-occupational accidents and diseases only. Diseases and accidents that arise out of or in the course of employment are not covered by this Plan.

## GOVERNMENTAL PLANS

No Medical Expense Benefits will be payable for any supplies or services for which no charge is made, or for which you are not required to pay, or furnished by or payable under any plan or law of any government, federal or state, dominion or provincial or any political subdivision thereof.

## ACTS OF THIRD-PARTIES

Expenses for services or supplies for which a third-party is required to pay are not covered. See Article XI on Subrogation and Reimbursement (and also Article XV) for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third-party is required to pay for those services or supplies.

# RULES AND REGULATIONS

**FOR ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES**
**OF THE ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND**
**Restated April 1, 2025**

## ARTICLE I: GENERAL DEFINITIONS

The following are definitions of general terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. There are also Articles in this document that contain definitions of terms pertaining to specific information found in that Article. For example, Article XV, about the Medical Plan, contains definitions applicable to the information described in that Article.

**Section 1:** The term "Active Employee" means an Employee who is employed under the Working Agreement between the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, Local Union No. 469 and the Arizona Mechanical Contractors Association, hereunder as established by the Fund and as amended from time to time. This definition does not include Medicare Retirees. See also the term "Employee."

**Section 2:** The term "Allowed Charge" means the amount the Dental PPO Plans allow as payment for eligible Medically Necessary services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

(a) **For a Network provider**, the fee set forth in the agreement between the Network Provider/facility and the Network or the Plan; **or**

(b) **For an Out-of-Network provider**, Allowed Charge amount means 150% of the amount that is payable in accordance with Medicare allowable amounts for the state of Arizona; **or**

(c) For a Network provider whose network contract stipulates that they do not have to accept the network discount for claims involving a third-party payer, including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as a Network claim; **or**

(d) The Provider's actual billed charge.

The Plan will not always pay benefits equal to or based on the Provider's actual charge for services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for eligible services or supplies.

**Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's Annual Out-of-Pocket Limit.** Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this Article

In the case where the Network Allowed Charge amount on an eligible claim exceeds the actual billed charges, the Participant and the Plan will pay their Plan Coinsurance on the lesser amount, the billed charges, and the Plan will pay the excess difference between the actual billed charges and the Network Allowed Charge amount in full.

**Section 3:** The term "Arizona Pipe Trades Plan" means the Plan provisions outlined in these Rules and Regulations which govern those individuals who are eligible to participate in the Arizona Pipe Trades Health and Welfare Trust Fund.

**Section 4:** The term "Balance Billing" means a bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged. Amounts associated with Balance Billing are not covered by this Plan, even if the Plan's Out-of-Pocket Limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Note that amounts exceeding the Allowed Charge do not count toward the Plan's Out-of-Pocket Limit and may result in Balance Billing by the provider to you. Typically, Network providers do not Balance Bill except in situations of third-party liability claims. Out-of-Network

Health Care Facilities or Practitioners commonly engage in Balance Billing a Plan Participant for any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid Balance Billing by using Network providers. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, non-emergency services by Out-of-Network providers at network facilities, or air ambulance services.

**Section 5:** The terms "Board of Trustees" and "Board" mean the Board of Trustees established by the Trust Agreement.

**Section 6:** The term "Calendar Year" means the period of 12 consecutive months commencing on January 1.

**Section 7:** The term COBRA participant refers to an employee or dependent who has elected COBRA continuation coverage.

**Section 8:** "Cost-sharing" means the amount of money a Plan Participant is to pay toward a service or item, versus the amount of money the Plan is to pay. Plans typically have three different types of cost-sharing provisions: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these types of cost-sharing. It is common to have a Plan change its cost-sharing provisions at least once each 12 months (more often if necessary).

**Section 9:** The term "Covered Person(s)" is used in the Medical Plan Benefits Article of this document to refer to an Employee, Early Retiree or Dependent who is eligible enrolled for coverage under the Medical plan.

**Section 10:** The term "Dentist" means a Dentist licensed to practice Dentistry in the state in which the Dentist renders treatment.

**Section 11:** The term "Dependent" means the Eligible Employee's/Retiree's:

(a) Lawful **Spouse** (as defined consistent with federal law.) The Plan may require proof of marriage which is a certified marriage certificate); or

(b) Any **unmarried or married child** of the Employee or Retiree, (proof of Dependent status is a birth certificate) including:

- **Natural child**,
- **Stepchild**,
- **Legally adopted child** or child placed for adoption with the Employee/Retiree,
- **Child** under Legal Guardianship as explained in (g) below;
- Child of an Eligible Employee/Retiree if required by a **Qualified Medical Child Support Order (QMCSO)**,

who is:

(1) Less than 26 years of age, (unless the disabled child provision applies); or

(2) **Disabled Child Provision**: Upon attainment of the age limit specified above, an unmarried child may continue eligibility under this Plan if the child is incapable of self-sustaining employment by reason of mental or physical disability, (provided the condition of the child existed before attainment of the age limit and while eligible hereunder) and who is primarily dependent upon the Eligible Employee/Retiree for financial support. Proof of disability and support may be required by the Plan.

(c) This Plan will provide coverage for a child of an Eligible Employee/Retiree if required by a **Qualified Medical Child Support Order (QMCSO)**, as defined herein. This Plan has established written procedures to determine if a court order is a qualified medical child support order and to administer benefits accordingly. Upon receipt of the order, the Administrative Office will promptly notify the Eligible Employee/Retiree, and each affected child, of the receipt of the order and the Plan's procedures for determining if the support order is qualified. The Eligible Employee/Retiree and each affected child will be notified within a reasonable period of time of the Plan's determination. The affected child may designate a representative to receive copies of any notices that are sent on his/her behalf. If the Plan determines that the order is qualified, the affected child will then be considered a Dependent under the Plan and will receive copies of the Summary Plan Description (SPD)/Plan Rules and Regulations, the Summary Annual Reports and a summary of any amendments made to the Plan according to current ERISA requirements. For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Administrative Office.

(d) **Adopted children** shall be considered eligible under this Plan when they are placed for adoption. The Employee must complete required enrollment documents. **Placed for adoption means** the assumption and retention by a covered Employee/Retiree of a legal obligation for total or partial support of the child in anticipation of adoption.

(e) Specific documentation to substantiate Dependent status satisfactory to the Administrative Office may be required. See Article II, Section 2(c)(3) on **proof of Dependent status**.

(f) Benefits under this Plan shall be provided to all eligible participating Dependents on the same basis as any other covered Participant.

(g) **Child Under a Legal Guardianship**: a child with respect to whom the Employee/Retiree has legal guardianship under a court order (proof of guardianship and age may be required) is eligible to **19 years of age**. Such child may continue eligibility under this Plan **to 24 years of age** only if the child is a full-time student. Proof of student status is required to be provided, each semester, to the Administrative Office and includes proof that the child is attending and enrolled at an accredited educational institution on a full-time basis as determined by the institution, or as determined by the Board of Trustees.

If the Plan receives a written certification from a child's treating Physician that (1) the child is suffering from a serious illness or injury, and (2) a leave of absence (or other change in enrollment) from a postsecondary institution is Medically Necessary, and if the loss of student status would result in a loss of health coverage under the Plan, the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the Medically Necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (i) one year later, or (ii) the date on which coverage would otherwise terminate under the terms of the Plan (for example, when the child reaches the Plan's limiting age).

(h) The following individuals are **not eligible** under the Plan: a foster child, a Spouse of a Dependent Child (*e.g.*, Employee/Retiree's son-in-law or daughter-in-law) or a child of a Dependent Child (*e.g.*, Employee/Retiree's grandchild) where there is no legal guardianship order on the Employee/Retiree, Domestic Partners and children of a Domestic Partner.

(i) With the exception of a Dependent Child who is permanently and Totally Disabled as noted above, coverage will terminate at the end of the month in which the individual attains age 26.

(j) A child must be less than 26 years of age with respect to Death benefits.

**Section 12:** The term "Early Retiree" means a person who meets the eligibility requirements for Early Retiree status as established by the Fund and as amended from time to time, and who is not yet entitled to Medicare benefits.

**Section 13:** The term "Eligible Employee" means each Active Employee and Self-Payment Employee of the Arizona Pipe Trades Plan.

**Section 14:** The term "Eligible Individual" means each Active Employee, Self-Payment Employee and each of their eligible Dependents, if any, of the Arizona Pipe Trades Plan.

**Section 15:** The term "Emergency" means vision or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such 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 placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

**Section 16:** The term "Employee" means the following:

- The term **"Active Employee"** means an Employee who is employed under the Working Agreement between the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, Local Union No. 469 and the Arizona Mechanical Contractors Association.
- The term **"Employee"** also includes: (1) corporate officers of signatory employers provided such employers have executed a participation agreement for all corporate officer Participants; (2) a regularly employed and salaried officer or business representative of the Union; and (3) an apprenticeship coordinator or assistant apprenticeship coordinator regularly employed by any apprenticeship committee established pursuant to any of such Collective Bargaining Agreements; and (4) those individuals eligible under non-job site participation rules.
- If an Employee is benefits eligible and enrolled under the Plan, that employee is referred to as an "**Eligible Employee**," "**Eligible Active Employee,**" or "**Covered Employee**." If the employee is self-paying for benefits, the employee may also be referred to as a "**Self-Pay Employee**."

- The term "**Eligible Individual**" refers to the Employee and any Dependents who are eligible for benefits and enrolled for coverage under the Plan.

**Section 17:** The term "Expense Incurred" means an expense is considered to be incurred on the date the service or supply is rendered or obtained.

**Section 18:** The term "Experimental and/or Investigational" is determined by the medical, dental and vison Claims Administrators under contract to the Plan. In the absence of an administrator's definition, or in other circumstances where the Trustees need to rely on a definition, under this Plan the term under this Plan the term "Experimental and/or Investigational" means the Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental or Investigational.

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

A service or supply will be deemed to be Experimental and/or Investigational or Unproven if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Utilization Management program, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:**

(a) The service or supply is described as an alternative to more conventional therapies in the protocols (the Plan for the course of vision or dental treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;

(b) The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

(c) In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational or unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

(d) With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.

(e) Note that under this vision or dental plan, experimental, investigational or unproven does not include routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.

For individuals who will participate in a clinical trial, **<u>precertification is required</u>** in order to determine if the Participant is enrolled in an "approved clinical trial" and notify the Plan's Claims Administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

(1) "**Routine costs**" means services and supplies incurred by an Eligible Individual during participation in a clinical trial if such expenses would be covered for a Participant or Beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

(2) An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC,

AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(3) A Participant or Beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating Health Care Provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

(4) The Plan may require that an Eligible Individual use a Network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

(5) The Plan may rely on a medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process.

See the Claim Filing and Appeals Procedures article for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

In determining if a service or supply is or should be classified as Experimental and/or Investigational or Unproven, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for Precertification under the Plan's Utilization Management program:**

(a) Medical or dental records of the Covered Person;

(b) The consent document signed, or required to be signed, in order to receive the prescribed service or supply;

(c) Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;

(d) Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the Covered Person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";

(e) The published opinions of the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the US such as Aetna, CIGNA or Unitedhealthcare, or MCG, formerly Milliman Care Guidelines or, the American Dental Association (ADA), with respect to dental services or supplies.

(f) Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.

(g) The latest edition of "The Medicare National Coverage Determinations Manual."

To determine how to obtain a Precertification of any procedure that might be deemed to be Experimental and/or Investigational or Unproven, contact the Utilization Management Program.

**Section 19:** The term **"Fund"** means the Arizona Pipe Trades Health and Welfare Trust Fund. The term "Fund" also means the Board of Trustees established by the Trust Agreement where applicable.

**Section 20:** The term **"He" or "His"** means either a male or a female unless a distinction is specified.

**Section 21:** The term "**Health Care Practitioner or Provider"** means a Physician, Behavioral Health Practitioner, Chiropractor, Dentist, Nurse, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Optometrist, Optician for Vision benefits, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his/her license and/or scope of practice; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

**Section 22:** The term **"HRA Participant"** means a person who is an Active Employee, a COBRA Participant, or a non-COBRA reduced self-payment Participant, for whom the required HRA contributions have been negotiated and paid. The Active Employee must be actually enrolled in a group health plan that provides minimum value pursuant to Internal Revenue Code §36(c)(2)(C)(ii), regardless of whether the group health plan is sponsored by this health and welfare fund.

**Section 23:** The term **"Medically Necessary"** is determined by the medical, dental and vison Claims Administrators under contract to the Plan. In the absence of an administrator's definition, or in other circumstances where the Trustees need to rely on a definition, under this Plan, the term "Medically Necessary" (or Medical Necessity) means:

(a) A medical, vision or dental service or supply will be determined to be "Medically Necessary" by the Plan Administrator or its designee if it:

(1) is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; **and**

(2) is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; **and**

(3) is determined by the Plan Administrator or its designee to meet **all** of the following requirements:

- It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
- It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; **and**
- It is an **"Appropriate"** service or supply given the patient's circumstances and condition; **and**
- It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; **and**
- It is safe and effective for the illness or injury for which it is used.

(b) A medical, vision or dental service or supply will be considered to be **"Appropriate"** if:

(1) It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as **and** no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

(2) It is care or treatment that is as likely to produce a significant positive outcome as **and** no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

(c) A medical, vision or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative Appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

(d) The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the medical, vision or dental coverage provided by the Plan.

(e) A Hospitalization or confinement to a Health Care Facility will **not** be considered to be Medically Necessary if the patient's illness or injury could safely and Appropriately be diagnosed or treated while not confined.

(f) A medical, vision or dental service or supply that can safely and Appropriately be furnished in a Physician's or Dentist's office or other less costly facility will **not** be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

(g) The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide health care services will **not** result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

(h) A medical, vision or dental service or supply will **not** be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

**Section 24:** The term **"Medicare"** as used herein, means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

**Section 25:** The term **"Medicare beneficiary"** means an individual who is determined by the Social Security Administration to be eligible for and has actually enrolled in Medicare benefits.

**Section 26:** The term **"Network Provider**" means Physicians, Health Care Practitioners, Hospitals and other ancillary providers that are part of the Preferred OAP network of health care facilities or practitioners/providers that provide discounted medical services to Eligible Individuals in the Medical Plan. CIGNA OAP providers are considered Network providers. Network Providers are sometimes referred to as In-Network providers.

**Section 27:** The term **"Physician"** means a person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his/her license **and** is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

**Section 28:** The term **"Plan"** means these Rules and Regulations as adopted and thereafter amended by the Board of Trustees.

**Section 29:** The term **"Participant" or "Plan Participant"** refers only to Active Employees, Retirees, and COBRA Participants who were formerly Active Employees. These terms do not include Dependents.

**Section 30:** The term "**Plan Year"** means the 12-month period beginning each June 1 through May 31. Benefits such as Deductibles and Plan maximums are accumulated on a 12-month Calendar Year basis.

**Section 31:** The term **"Preferred Provider Organization (PPO) Provider**" means Dentists and other licensed Dental Practitioners and other ancillary providers that are part of a preferred dental network that provide discounted dental services to Eligible Individuals in the Dental PPO Plan.

**Section 32:** The term **"Qualified Medical Child Support Order (QMCSO)"** means, according to the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), a qualified medical child support order that is generally in the form of a court order resulting from a divorce, which designates one parent to pay for a child's health coverage. The order may require the Plan to accept contributions from a parent who is not an Eligible Individual provided the child's other parent is an Eligible Employee. To be qualified, the order must clearly specify:

(a) The name and last known address of the Eligible Employee and the name and mailing address of each child covered by the order;

(b) A reasonable description of the type of coverage to be provided by the Plan to each child, or the manner in which such type of coverage is to be determined;

(c) The period for which the order applies; and

(d) Each Plan to which the order applies.

The support order may not require that the Plan provide any type or form of benefit that is not otherwise provided the Eligible Individual except to the extent necessary to meet the requirements of the state medical child support law.

**Section 33: Residential Treatment Program/Facility/Care** is a non-acute hospital, intermediate inpatient setting with 24-hour level of care that operates seven days a week, for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a residential treatment facility. Licensure requirements for this residential level of care may vary by state.

**Section 34: The term "Retiree"** refers to an Early Retiree as that term is defined in this Plan.

**Section 35:** The term **"Self-Payment Employee"** means any person who meets the self-pay eligibility requirements of the Arizona Pipe Trades Plan, hereunder as established by the Fund as amended from time to time.

**Section 36:** The term **"Totally Disabled"** means, with respect to an Eligible Employee, the individual is prevented by reason of bodily injury or sickness from engaging in any occupation for which the individual is or becomes qualified by reason of education, training or experience, and with respect to a Dependent, the individual is unable by reason of bodily injury or sickness, to engage in the normal activities or duties of a person of the same age and sex.

**Section 37:** The term **"Trust Agreement"** means the Agreement and Declaration of Trust establishing the Arizona Pipe Trades Health and Welfare Trust Fund and any modification, amendment, extension or renewal thereof.

# ARTICLE II: ELIGIBILITY FOR BENEFITS

**Section 1: Definitions.**

(a) The term **"Active Employee"** as used herein means an Employee who is employed under the Working Agreement between the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, Local Union No. 469 and the Arizona Mechanical Contractors Association.

(b) The term **"Employee"** also includes: (1) corporate officers of signatory employers provided such employers have executed a participation agreement for all corporate officer Participants; (2) a regularly employed and salaried officer or business representative of the Union; and (3) an apprenticeship coordinator or assistant apprenticeship coordinator regularly employed by any apprenticeship committee established pursuant to any of such Collective Bargaining Agreements; and (4) those individuals eligible under non-job site participation rules.

(c) The term "**Early Retiree"** a person who meets the eligibility requirements for Early Retiree status as established by the Fund and as amended from time to time, and who is not yet entitled to Medicare benefits. See the Important Information for Early Retirees in the front of this document.

(d) The term "**Enroll**" means the steps the employee must take to sign up/register an eligible Dependent for coverage under the Plan. These steps include

(1) Contacting the Administrative Office to request enrollment (the contact information for the Administrative Office is listed on the Quick Reference Chart in the front of this document);

(2) Completion of the Plan's enrollment form which includes the dependent's Social Security number (SSN) or taxpayer identification number (TIN);

(3) Providing proof of dependent status if dependent enrollment is being requested; and

(4) Performing these three steps in a timely manner.

It is important that the Administrative Office have a completed and current enrollment form in order for claims to be processed. An enrollment form is available from your Local Union Office or from the Administrative Office. You must complete a new enrollment form in the event that:

(1) You change your home address.

(2) You wish to add or change your Beneficiary.

(3) There is any change in your family status by reason of marriage, birth of a child, adoption or placement for adoption, loss of other coverage, death, divorce or legal separation.

Proper enrollment is required for coverage under this Plan. Failure to notify the Plan in a timely fashion of these changes may jeopardize an individual's rights to coverage and will subject you (and may subject your Spouse) to repaying amounts that were paid on behalf of a person rendered ineligible by the changed circumstance. If enrollment has been requested within the required time limit but completion of the enrollment form not been completed and submitted to the Administrative Office, claims will not be able to be considered for payment until such enrollment form has been completed and submitted.

**A person who has not properly enrolled by completing the Plan's enrollment procedures (noted above) has no right to any coverage for Plan benefits or services under this Plan.**

**Section 2: Eligibility Provisions.**

(a) **Establishment and Maintenance of Eligibility.**

(1) All Active Employees of contributing employers for whom such contributing employers are required to pay monies to the Fund for the maintenance of a health and welfare plan, including corporate officers of signatory employers, provided such employers have executed a participation agreement for all corporate officer Participants, shall be eligible for Fund benefits on the first day of the second calendar month following a period of time of not more than three consecutive months, during which the Active Employee has worked at least **150 hours** for one or more contributing employers.

**For Active employees eligible as of October 2006, eligibility for the benefits provided by the Health and Welfare Plan is earned under the "Hour Bank Plan."** Eligibility shall continue for an

Active Employee if his/her Hour Bank maintains sufficient hours of work credit for the current month's eligibility as set forth in Section 2(a)(2) of this Article II.

**Non-bargaining non-alumni employees** who first became eligible after 2006 do not have hour bank eligibility and instead, eligibility is determined on a month to month basis.

(2) **An Hour Bank** is an account of hours established for each Active Employee, and includes all hours credited thereto less all hours deducted therefrom, as provided below:

(A) Subject to the maximum set forth in Paragraph (C) of this Subsection (a)(2), all hours worked by an Active Employee (including non-bargaining alumni) for one or more contributing employers shall be credited to the Active Employee's Hour Bank.

(B) Hours of work credit shall be deducted from an Active Employee's Hour Bank for each month of eligibility at the rate of **150 hours** per month for the first 24 continuous months of eligibility and **140 hours** per month thereafter.

(C) The maximum balance in an Active Pipe Trades Employee's Hour Bank shall be **700 hours (up to 1,120 hours) after** the 150 or 140-hour deduction has been made for the current month's eligibility. An active Pipe Trades Employee is an individual who is having contributions made on his/her behalf at the Building Trades Journeyman rate. An Employee classified as a Metal Trades Journeyman, who is having contributions made on his/her behalf at the Building Trades Journeyman rate (not including the Retiree Health Contribution) shall accumulate an hour bank of 700 hours. All other Metal Trades Employees shall be eligible for a maximum balance of 450 hours after the current month's eligibility has been deducted.

(D) Effective January 1, 2017, members that currently have in excess of 700 hours will not forfeit the excess hours and instead will be subject to the new hour bank maximum once their hour bank is less than the 700-hour maximum.

(E) Non-bargaining non-alumni employees who first became eligible after 2006 do not have hour bank eligibility and instead, eligibility is determined on a month to month basis.

(F) Effective January 1, 2023, through June 30, 2025, an Indentured Apprentice shall be credited for actual hours, not to exceed 40 hours for any week, that the apprentice attended the day-time training program administered by the Arizona Pipe Trades Joint Apprenticeship Committee.

(3) In accordance with the **Family and Medical Leave Act of 1993 (FMLA)**, qualified Employees are entitled to 12 weeks (in some cases up to 26 weeks) of unpaid leave and can continue to maintain coverage under this Plan for the duration of the leave. Qualifications for this provision are outlined in the act and subsequent regulations.

(4) In accordance with the **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**, qualified individuals are entitled to unpaid leave in the event they are called to active military service for a period exceeding 31 days, and can continue to maintain coverage under this Plan during the related active military service. Qualifications for this provision are outlined in the Act and subsequent regulations.

If a qualified individual elects USERRA continuation coverage on or after December 10, 2004, the maximum period for this coverage is up to 24 months.

(5) **Temporary eligibility change, effective for participants dispatched for work between July 1, 2021, through December 31, 2025, only:** Except for first-year apprentices, New Active Employees, as defined below, will have 340 hours advanced to their hour bank (an "hour bank loan") in their first month of work. Coverage will then begin the first of the month following the month employment began. Each month, any hours worked will apply first toward the minimum 150 hours required to maintain eligibility. Any excess will be applied to repay the member's hour bank loan.

(A) In order to qualify as a New Active Employee, one must:

(i) Be dispatched to work in the jurisdiction of the Plan by Local 469 to a Contributing Employer between June 1, 2021, and **December 31, 2025**;

(ii) Not have any Covered Hours under or participated in the Plan in the 24 months prior to dispatch and beginning employment; and

(iii) Have had employer sponsored medical coverage in the month of or prior to dispatch by Local 469.

(B) Exceptions and Limitations:

(i) If the hour bank loan is not fully repaid after 24 months of the New Active Employee's month of initial eligibility, then the obligation to repay the hour bank loan will end and any remaining hour bank loan hours will be cancelled. At that point, the member must satisfy the continuing eligibility requirements under the Plan in order to continue coverage.

(ii) If during the first 12 months of coverage a New Active Employee loses Plan coverage and has an outstanding hour bank loan, the loan and banked hours will be cancelled. In order to have coverage reinstated, the member must reestablish Initial Eligibility by working at least 150 Covered Hours within three consecutive months.

(iii) The Plan must follow the National Reciprocity Agreement; so, if your home local is not Local 469 you are ineligible for the loan or for any other Plan coverage.

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

(6) **Eligibility for Existing Employees of Newly Signatory Employers**

(A) Effective January 1, 2022, upon an Employer signing the Arizona Pipe Trades Agreement ("Agreement") or a memorandum adopting the Agreement's terms and conditions, the Fund shall advance an hour bank to Employees of the Employer if:

(i) The Employer was not bound to the Agreement within the last five years;

(ii) The Employee (1) worked at least 120 hours for the Employer during the immediately prior 30 calendar days performing work of the type covered by the Agreement and (2) was covered by the Employer's sponsored health insurance for at least that time period; and

(iii) The Employer has submitted documents to the Fund Administrator establishing that the Employee meets the criteria in Paragraph (A)(ii) and specifying the date that coverage under the Employer's sponsored health insurance ends.

(B) 400 hours will be advanced to the hour bank of each Employee (called an "Eligible Employee") who meets the requirements specified in Paragraph (A). The advance will be made to provide coverage on the first day of the month after an Eligible Employee loses coverage under the Employer's sponsored health insurance.

(C) Exceptions and Limitations:

(i) If an Eligible Employee works more than 150 hours in any subsequent month, the excess hours shall be used to repay the 400 hours advanced by the Trust Fund.

(ii) If the 400-hour bank loan is not fully repaid after 36 months of the Employee's month of initial eligibility, then the obligation to repay the hour bank loan will end and any remaining hour bank loan hours will be cancelled. At that point, the Employee must satisfy the continuing eligibility requirements under the Plan in order to continue coverage.

(iii) If during the first 12 months of coverage an Eligible Employee loses Plan eligibility, the loan and any remaining banked hours will be cancelled. In order to have coverage reinstated, the member must reestablish Initial Eligibility by working at least 150 Covered Hours within three consecutive months.

(iv) Notwithstanding anything to the contrary herein, the Plan must follow the National Reciprocity Agreement; so, if the Employee's home local is not Local 469, the Employee is ineligible for the loan or for any other Plan coverage.

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

(b) **Reinstatement of Eligibility.**

(1) If an Active Employee's eligibility terminates, it can be reinstated if his/her Hour Bank shows a total of at least **140 hours** (**150 hours** if the Active Employee has been continuously eligible for less than 24 months) within the two-year period subsequent to the termination of eligibility.

(2) Such reinstatement shall be effective on the first day of the second month that follows the month in which this requirement is met.

(3) If an Active Employee's eligibility is not reinstated, any hours remaining in his/her Hour Bank shall be canceled; such Active Employee shall again become eligible only by satisfying the eligibility requirements of a new Employee as set forth in Section 2(a) of this Article II.

(c) **Eligibility of Dependents of Active Employees and Retirees.**

(1) **Dependent Eligibility**: Employees and Retirees must enroll their eligible Dependent (Spouse and children) in order for those Dependents to be eligible for benefits under the Plan. There are three opportunities to enroll Dependents for coverage under this Plan: Initial Enrollment (becoming enrolled at the same time the Employee/Retiree is first eligible), New Dependent Enrollment, and Rolling Enrollment. Retirees must enroll their eligible Dependents when they start eligibility as a Retiree.

(A) **Initial Eligibility Enrollment**: This is the first opportunity for the Employee/Retiree to enroll his/her eligible Dependents. A newly eligible Participant has 90 days in which to enroll his/her Dependents. If the Dependent is enrolled **within 90 days** of the Employee/Retiree's initial eligibility, the eligible Dependent's coverage will become effective on the date the Employee/Retiree's initial eligibility becomes effective. Failure to enroll during Initial Enrollment means the Dependent will not receive coverage until the first day of the first month after the Employee/Retiree does enroll the Dependent (see the Rolling Enrollment provision below).

(B) **New Dependent Enrollment**: This is the first opportunity for the Employee/Retiree to enroll a Dependent because of an event such as marriage, birth, adoption, or placement for adoption. If an Employee/Retiree enrolls a new Dependent Child (newborn/adopted/placed for adoption/new stepchild) or a new Spouse **within 90 days** of the event (the child's birth, adoption, placement for adoption, or the Employee/Retiree's marriage), coverage is effective as of the date of the event. Failure to enroll during New Dependent Enrollment means the Dependent will not receive coverage until the first day of the first month after the Employee/Retiree does enroll the Dependent.

(C) **Rolling Enrollment**: If any Dependents are not enrolled within the first 90 days of the Employee/Retiree's initial eligibility or the date the person first became a new Dependent, the Employee/Retiree may enroll them at any time, but coverage is not effective until the first day of the month after enrollment, not retroactively.

(D) This Plan complies with the Federal law regarding **Special Enrollment**. Your eligible Dependents may also enroll in this Plan if the Dependents:

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and lose eligibility for that coverage. However, you must request enrollment in this Plan within 90 days after the Medicaid or CHIP coverage ends; or
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 90 days after your Dependents are determined to be eligible for such premium assistance.

(2) **How to Enroll a Dependent for Benefits.**

(A) To request enrollment, an Employee/Retiree must contact the Administrative Office (by telephone, fax, postal service mail or hand delivery) and indicate his/her desire to enroll his/her Dependent in the Plan or complete and submit an enrollment form from the Fund's website. (The contact information for the Administrative Office and Fund's website is listed on the Quick Reference Chart in the front of this document.) Once enrollment is requested, the Employee/Retiree will be provided with the steps to enroll that include all of the following:

- Submit a completed written enrollment form(s) (that may be obtained from and submitted to the Administrative Office), and
- Provide proof of Dependent status (as requested), and
- Perform these steps above in a timely manner according to the timeframes noted under the Initial, New Dependent, or Rolling Enrollment provisions of this Plan.

Proper enrollment is required for coverage under this Plan.

(B) Note that if enrollment has been requested within the required time limit but proper enrollment including paperwork and Social Security Number has not been completed and submitted, claims will **not** be able to be considered for payment until such information has been completed and submitted to the Administrative Office.

(C) **Dependent Social Security Numbers Needed.**

**DEPENDENT SOCIAL SECURITY NUMBERS NEEDED**

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

If a dependent does not yet have a Social Security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a Social Security number is FREE. Failure to provide the SSN or complete the CMS model form (form is available from the Medical Plan Claims Administrator or https://www.cms.gov/files/document/mmsea-111-mbi-ssn-collection-ghp-model-language.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

(D) **A person who has not properly enrolled by requesting enrollment in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.**

(3) **Proof of Dependent Status.**

In order for claims to be processed, an enrollment form must be completed along with the required Social Security Number (SSN) and proof of Dependent status and submitted to the Administrative Office. Documents needed for proof of Dependent status include the following, although additional documentation might be needed depending upon circumstances:

(A) Spouse: marriage certificate.

(B) Dependent Child: birth certificate, QMCSO proof.

(C) Disabled Dependent Child age 26 and older: Social Security award letter, birth certificate or other proof of disability and date of disability. You will have 31 days from the date of the request to provide this proof before the child is determined to be ineligible.

(D) Stepchild: birth certificate, and marriage certificate between Participant and child's parent.

(E) Adopted Child: birth certificate, adoption decree or documentation proving placement for adoption.

(F) Child under Legal Guardianship: birth certificate, guardianship court order, income tax returns showing the child is dependent on Participant for support.

(d) **Termination of Eligibility.**

(1) An **Active Employee's eligibility** will terminate on the last day of the month in which any of these events occur:

(A) The individual does not qualify under Section 2 of this Article II.

(B) Entrance into full-time active duty with the armed forces of any country, except as specified in Section 2(a)(4) of this Article II.

(C) The individual takes employment in Arizona in any capacity or continues employment in Arizona in any capacity with any employer **not** obligated to contribute to the Fund.

(D) The individual engages in any kind of commercial business activity in Arizona as a sole proprietor, partner, contractor or commissioned agent without being signatory to a labor agreement with Local Union 469 requiring contributions to the Fund.

(E) The individual is disabled, on Medicare due to that disability, and has reached age 65.

For purposes of paragraphs C and D, work on a part-time or temporary full-time basis, other than at the trade or in the plumbing, pipefitting and refrigeration industry, shall not cause the automatic forfeiture and cancellation, provided the individual continues to evidence his/her desire to continue work for contributing employers by maintaining his/her registration at the hiring halls of Local Union 469.

For purposes of paragraphs C and D, this will constitute cancellation of the Hour Bank credits, and self-pay rights at the reduced premium, as described in Option I of Section 2(e) of this Article.

(2) The **eligibility of a Dependent** of an Active Employee will terminate on the last day of the month in which any of these events occur:

(A) The Active Employee's eligibility terminates.

(B) The Spouse's, entrance into full-time active duty with the Armed Forces of the United States.

(C) The individual no longer qualifies as a Dependent, as defined in Article I.

**NOTE:** Notwithstanding anything in the Rules and Regulations to the contrary, whenever Dependent eligibility ceases for any reason, notification of such event must be made to the Administrative Office within 30 days of the event. **Failure to give this Plan a timely notice (as noted above) may cause** your Spouse and/or Dependent Children to lose their right to obtain COBRA Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a Participant's liability to the Plan if any benefits are paid to an ineligible person.

(D) The Administrative Office receives a final order issued by a court of competent jurisdiction requiring the Participant to disenroll the Dependent. A Dependent who is disenrolled under this Paragraph shall be eligible for enrollment at a later time as provided by the Rolling and Special Enrollment provisions of Section 2(c)(1)(C)-(D) above.

(E) A Dependent who is at least 18 years of age submits to the Administrative Office an executed Waiver of Coverage form. A Dependent who is disenrolled under this Paragraph shall be eligible for enrollment at a later time as provided by the Rolling and Special Enrollment provisions of Section 2(c)(1)(C)-(D) above.

(3) **When The Plan Can End Coverage For Cause.**

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

(A) The Plan Administrator or its designee may end a Participant's coverage for cause 60 days after it gives the Participant written notice of its finding that the Participant:

(i) **Engaged in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact** in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or

(ii) **Allowed anyone else to use the identification card** that entitled the Participant to coverage, services or benefits under the Plan; or

(iii) **Altered any prescription** furnished by a Physician or other Health Care Practitioner.

If coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that the Participant performed or permitted the acts described above.

(B) The Plan Administrator or its designee may end coverage for cause 30 days after it gives the Participant written notice of its finding that the Participant engaged in **conduct that was abusive, obstructive, or otherwise detrimental to a Physician or Health Care Practitioner**. If coverage is terminated for this reason, it will be terminated on a going forward basis.

(e) **Self-Payment Provisions.**

(1) **Active Employees Self-Payments.**

(A) If an Active Employee loses eligibility under the Hour Bank provisions because of the termination or reduction in hours of employment, the Active Employee and/or his/her eligible Dependents may continue eligibility by making self-payments directly to the Administrative Office. If the insufficiency of hours in the Active Employee's Hour Bank is due to retirement, such Employee may, if the individual otherwise qualifies for the Early Retiree benefit of Subsection (2) of this Section 2(e) be eligible to elect between coverage under these provisions or coverage under the Early Retiree Self-Payment Option.

(B) **Notice.** The Administrative Office will notify an Active Employee and his/her Dependents who have lost eligibility under the Hour Bank provisions. The affected persons will have until the later of 60 days from the date of such notice, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making self-payments.

(C) **Coverage Available - Self-Payment Premium.** An Active Employee electing to continue eligibility for himself/herself and/or his/her eligible Dependents on a self-payment basis can choose between the Options expressed below, depending upon his/her eligibility for those Options:

(i) **NON-COBRA Reduced Self-Payment OPTION 1:**

Under this Option, an Active Employee electing to continue eligibility for himself or herself and his/her eligible Dependents on a self-payment basis may **continue Medical Plan and Weekly Disability benefits only**. Any Participant who has been continuously eligible in the Plan for 36 months out of the last 42 consecutive months may continue coverage under Option 1 for **up to 12 months** at a reduced self-pay rate, beyond the date coverage would otherwise terminate because the number of hours in his/her Hour Bank drops below the number of hours required for the current month's coverage.

Reduced self-payment rates are not available to Participants whose coverage has been terminated as a result of engaging in prohibited employment as outlined in the paragraphs numbered 1 and 2 of the "Termination of Benefits" Section noted above.

After 12 months on Option 1, the individual can elect to continue Medical Plan **and Weekly Disability** benefits for up to six more months and can now choose to add Dental PPO Plan and/or Vision benefits. There is no coverage available under Option 1 after a total of 18 months of Medical Plan coverage unless the individual is disabled.

(ii) **COBRA Self-Payment OPTION 2:**

Under this Option, an Active Employee electing to continue eligibility for himself or herself and his/her eligible Dependents on a COBRA self-payment basis can choose to **continue Medical Plan, Dental PPO Plan, Weekly Disability and Vision**

**benefits**. The amount of the self-payment premiums for each Option will be established by the Board of Trustees, and is subject to change at their discretion.

Note that for a COBRA Qualified Beneficiary who elected Medical Plan, Dental PPO Plan Weekly Disability and Vision benefits and who is no longer eligible to participate in COBRA's Medical Plan coverage because of the Qualified Beneficiary's entitlement to Medicare, the Plan will permit the COBRA Qualified Beneficiary to continue to self-pay his/her COBRA premium to continue coverage under the Dental PPO Plan and Vision benefits for the remainder of the months of COBRA coverage.

**Other Health Coverage Alternatives to COBRA:** Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

(D) **Maximum Period of COBRA Self-Payments.**

Once COBRA Coverage has been elected, it may be cut short (terminated early) on the occurrence of certain events, explained here. The right of an Active Employee and/or his/her eligible Dependents to make COBRA self-payments shall be continued until the end of the month in which the earliest of the following events occurs:

(i) Coverage ceases by reason of the failure to make timely COBRA self-payments (in full) required by the Board of Trustees.

(ii) The Qualified Beneficiary first becomes, after the date of election, covered under any group health plan, including, this Plan. **NOTE:** If the other plan contains lawful limitations or exclusions for any pre-existing conditions, any individual so limited or excluded by the other plan may continue coverage until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Paragraph (D).

(iii) The Active Employee and/or his/her eligible Dependent first becomes, after the date of election, entitled to Medicare; or

(iv) In the case of a covered individual who enters the Uniformed Services of the United States, the day after the date on which the person fails to apply for and return to a position of employment, as determined under Section 4312(e) of USERRA.

(v) During an extension of the maximum coverage period to 29 months due to the disability of the Covered Person, the disabled person is determined by the Social Security Administration to **no longer be disabled.**

(vi) The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA Participants under the Plan).

(vii) The Fund ceases providing any benefits to any Participant.

Notwithstanding the foregoing:

(i) In the event that an Employee becomes entitled to Medicare while eligible as an Active Employee and loses coverage by virtue of entitlement to Medicare, no Dependent of such Employee shall be denied the right to this provision until 36 months have passed from the date the Employee became entitled to Medicare. Medicare entitlement is not a Qualifying Event under the Plan and, as a result, Medicare entitlement following a termination of coverage or reduction in hours will

not extend COBRA to 36 months for Spouses and Dependents who are Qualified Beneficiaries.

(ii) In the case of an individual who was totally and permanently disabled for Social Security award purposes within 60 days of the employment termination of an Active Employee, up to 11 additional months of self-payments may be allowed to bridge the gap between these provisions and Medicare entitlement. In order to enjoy this additional extension of self-pay rights, the Totally Disabled individual is **required to notify the Administrative Office (following the COBRA Notice Procedures outlined in this Article)** within 60 days of the date of Social Security's determination that he/she was disabled at the time of the termination of employment, and before the end of the 18-month period described above. Such individual is also required to notify the Administrative Office (following the COBRA Notice Procedures outlined in this Article) within 30 days of any final Social Security determination that he/she is no longer disabled. The additional disability extension of self-payment rights under this Subsection will terminate at the end of the month following the month in which a final Social Security determination is made that the individual is no longer disabled.

(2) **Early Retiree Self-Payment Option** (for Early Retirees who are receiving a pension award from the Arizona Pipe Trades Pension Trust Fund).

An Early Retiree, who has been eligible for Fund benefits for at least 36 months out of the prior 42 consecutive months (not to include more than six months of COBRA self-pay Option 2) immediately preceding the first month the individual receives a pension award from the Arizona Pipe Trades Pension Trust Fund and is not entitled to Medicare can continue Medical Plan benefits only if the individual so elects upon timely payment of the proper self-payment rate, as determined by the Board, to the Administrative Office. An Early Retiree must elect coverage under this provision within 30 days of the effective date of the individual's pension, or within 30 days after the individual has insufficient hours in their Hour Bank or the individual's Hour Bank has been exhausted.

Notwithstanding the previous paragraph, an individual who receives a pension award from the Arizona Pipe Trades Pension Trust Fund, may also participate in the Medical Plan provided the individual was continuously eligible for benefits a minimum of 25 consecutive years under the Arizona Pipe Trades Health and Welfare Trust Fund and the individual left covered employment but did not perform work of the type covered under the Collective Bargaining Agreement provided the individual elects coverage and begins making self-payments within 30 days of the effective date of the individual's pension or within 30 days after the individual has insufficient hours in their Hour Bank or the individual's hour bank has been exhausted.

**IMPORTANT NOTE:**

THE ELECTION TO PARTICIPATE IN THE MEDICAL PLAN MUST BE MADE AT THE TIME THE INDIVIDUAL FIRST RECEIVES A PENSION AWARD FROM THE ARIZONA PIPE TRADES PENSION TRUST FUND OR ON THE DATE FOLLOWING THE PENSION AWARD IN WHICH THE INDIVIDUAL EXHAUSTS HIS OR HER HOUR BANK.

IF THE INDIVIDUAL RETURNS TO WORK AND ESTABLISHES ELIGIBILITY AS AN ACTIVE EMPLOYEE AND THEN LOSES THAT ELIGIBILITY, HE MAY RESUME PARTICIPATION IN THIS PLAN AS AN EARLY RETIREE, UPON PAYMENT OF APPROPRIATE SELF-PAYMENTS, SO LONG AS HE MAINTAINS CONTINUOUS ELIGIBILITY.

AN INDIVIDUAL WHO QUALIFIES UNDER THE 25 CONSECUTIVE YEAR REQUIREMENT (OR HIS/HER SPOUSE) MAY DEFER THE ELECTION TO PARTICIPATE IN THE MEDICAL PLAN PROVIDED THE PERSON RETAINS CONTINUOUS COMPARABLE COVERAGE UP TO THE DATE OF PARTICIPATION IN THE MEDICAL PLAN.

Once COBRA Coverage has been elected, it may be cut short (terminated early) on the occurrence of certain events, explained here. Continuation of the benefits described in this Subsection applies to the Self-Payment Employee and/or his/her eligible Dependents; payments can be continued until the earliest of the following events occurs:

(A) The Fund ceases providing benefits to Early Retirees.

(B) The Fund ceases providing any benefits to any Participant.

(C) Coverage ceases by reason of the failure of the Early Retiree to make timely self-payments (in full) required by the Board of Trustees.

(D) The Early Retiree and/or eligible Dependents first becomes, after the date of election, entitled to Medicare. (NOTE: You should be enrolled under Medicare Part A or B and/or C in order to receive the maximum amount of benefit. Arizona Pipe Trades Plan will no longer be your primary insurance once you and/or your Dependents become entitled to Medicare. This rule applies whether you choose Medicare or not. It is the responsibility of the Early Retiree and/or his/her eligible Dependents to notify the Administrative Office within 60 days of the Medicare entitlement. Medicare Eligible Individuals who are disabled and under age 65 may continue coverage under this Plan and covered Dependents who are not yet eligible for Medicare may remain covered under this Plan.)

(3) **Dependent COBRA Self-Payment.**

(A) If any Dependent loses coverage for the benefits of the Fund because of: (1) the death of an Active Employee or Self-Payment Employee; or (2) the divorce from an Active Employee or Self-Payment Employee; or (3) the loss of coverage due to attainment of Medicare entitlement by any Self-Payment Employee; or (4) in the case of a Dependent Child, ceasing to be a Dependent Child as defined by these Rules and Regulations, he/she may continue eligibility by making COBRA self-payments directly to the Administrative Office.

(B) **Notice from Dependent.** Dependents whose coverage under this Plan is affected by death, divorce, Medicare entitlement or a Dependent Child ceasing to be a Dependent Child as defined by these Rules and Regulations are responsible for notifying the Administrative Office of those facts (following the COBRA Notice Procedures outlined in this document) within 60 days of the affecting event. The Administrative Office will then notify the Dependents of their rights under these provisions within 14 days. The Dependents will have until the later of 60 days from the date of the notice from the Administrative Office, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making self-payments.

(C) **Coverage Available - COBRA Self-Payment Premium.** The amount of the monthly COBRA self-payment premiums for Dependents will be established by the Board of Trustees. The self-payments charged represent continuation of all health-related benefits provided for those Dependents as of the date the Dependents would have otherwise lost eligibility, or, if the Dependents so elect, only Medical Plan benefits.

(D) **Maximum Period of Self-Payment.** The right of Dependents to make self-payments shall be continued until the end of the month in which the earliest of the following events occurs:

(i) Coverage ceases by reason of failure of the Qualified Beneficiary to make timely COBRA self-payments (in full) required by the Board of Trustees.

(ii) The Dependent first becomes, after the date of election, entitled to Medicare whether enrolled in Medicare or not. This Arizona Pipe Trades Plan will no longer be your primary insurance. (Refer instead to the Fund's separate Medicare HRA Plan Rules and Regulations document.)

(iii) The Dependent first becomes, after the date of election, covered under any group health plan, including, without limitation, this Plan. **NOTE:** If the other plan contains limitations or exclusions for any pre-existing conditions, any individual so limited or excluded by the other plan may continue coverage under the Fund until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Subsection.

(iv) During an extension of the maximum coverage period to 29 months due to the disability of the Covered Person, the disabled person is determined by the Social Security Administration to **no longer be disabled.**

(v) 36 months have passed since the initial loss of eligibility under this Plan.

(vi) The Fund ceases providing any benefits to any Participant.

(4) **Payment of Self-Payment Premium for Active Employees, Early Retirees and their Dependents.**

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

(B) Each subsequent self-payment is **due on the first day of the month** for which coverage is intended.

(C) **Grace Period:** After the initial 45-day self-payment grace period, subsequent self-payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated above, COBRA Coverage will be canceled as of the due date. Payment is considered made when it is postmarked. **Self-payments received at the Administrative Office later than 30 days after the due date will not be accepted, and rights to self-payment will terminate.** Denials are subject to the Participant's right to appeal.

(D) **For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?** If the COBRA Administrator receives a COBRA premium payment that is not for the full amount due, the COBRA Administrator will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred. If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the end of the month in which the last full COBRA premium payment was made.

(5) **Trustee Rights.** The Board of Trustees reserves the right to request and receive from Self-payment Employees and Dependents any pertinent information bearing on the eligibility of such persons for the benefits provided under the self-payment provisions of the Fund. The failure of any such person to promptly respond to the Board of Trustees' request for such information will result in self-payment rights described herein being suspended or terminated by the Board of Trustees, at their discretion.

(6) **Persons Whose Eligibility is Affected by Multiple Events.** Notwithstanding anything to the contrary herein, no person may enjoy any one continuous self-pay coverage extension under the Fund beyond 36 months from the end of the month in which the first event giving rise to self-payment rights with respect to that person occurred. For these purposes, participation in the Early Retiree self-payment program is not considered an event giving rise to self-payment rights.

(7) **Notice of Unavailability of COBRA or Early Termination of COBRA.**

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

(B) The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

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

(8) **The Trade Act.**

(A) The Trade Adjustment Assistance Reform Act of 2002 (also called the Trade Act or TAA Program) creates a variety of benefits and services including a health coverage tax credit (HCTC) for certain individuals who have become eligible for Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA), and for certain retired Employees receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (called Eligible Individuals).

The health coverage tax credit is designed to help reduce the Out-of-Pocket cost of COBRA coverage for individuals who have become unemployed as a result of increased imports from, or shifts in production to, foreign countries. Because the HCTC is authorized under federal law, the rules for program eligibility are subject to change. If these provisions conflict with current federal law, then that law will apply. HCTC Eligible Individuals can either take a tax credit or get help paying their premiums as they become due.

If you have questions about these rules contact the United States Department of Labor Employment and Training Administration, the Division of Trade Adjustment Assistance at phone: 1-888-365-6822 or website: http://www.doleta.gov/tradeact or the HCTC website at: https://www.irs.gov/credits-deductions/individuals/hctc.

(9) **COBRA Notice Procedure.**

(A) Notices must be sent in writing to the Plan's COBRA Administrator who is the Administrative Office (at their address listed on the Quick Reference Chart in the front of this document). The written notice can be sent via first class mail, email, or fax, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents or proof of Social Security Administration disability determination.

# ARTICLE III: DEATH, ACCIDENTAL DEATH AND DISMEMBERMENT AND WEEKLY DISABILITY BENEFITS

**Section 1: Death Benefit.**

**This is a brief overview of benefits** for Eligible Active Employees (and an Active Employee eligible for Weekly Disability benefits also includes a COBRA self-pay Employee) only**. For more complete information on the Death and AD&D benefits refer to the certificate of insurance available from the Life Insurance Company whose name is listed on the Quick Reference Chart in the front of this document.**

(a) **Your Death Benefit:** Effective on the later of June 1, 2001 or the day the Eligible Active Employee becomes insured, if an Eligible Active Employee of the Arizona Pipe Trades Plan dies while eligible or within 31 days following the termination of the Eligible Active Employee's eligibility, the Fund will, subject to the provisions hereafter stated, pay a Death benefit to the Eligible Active Employee's Beneficiary of: $50,000.

(b) **Beneficiary:** If you do not select a Beneficiary, or if your Beneficiary does not outlive you, the above amount will be paid in this order to the living:

(1) Spouse;

(2) Children, including legally adopted children;

(3) Parents;

(4) Brothers and sisters;

(5) Executor or administrator.

If two or more persons are entitled to benefits, they will share equally. You may change your Beneficiary at any time. You may not assign the Death Benefits.

(c) **Extended Benefit:** If an Eligible Active Employee is Totally Disabled while covered under the Plan and before the individual reaches age 60, the Death Benefit then in effect will be extended for the duration of such disability provided satisfactory proof of disability is submitted to the Administrative Office before the expiration of 12 months from the date disability commenced. The Eligible Active Employee will be required periodically to submit proof of continued total disability. Your coverage will cease when you are no longer disabled.

The full amount of your Death Benefit in force on the date of your death will be paid to your Beneficiary if your total disability continues until such date, provided written notice is furnished to the Administrative Office within 12 months of the date of death.

**Section 2: Accidental Death and Dismemberment (AD&D) Benefits.**

(a) **Accidental Death Benefit:** If an Eligible Active Employee of the Arizona Pipe Trades Plan sustains bodily injuries solely through external, violent and accidental means, and dies as a result of such injuries within 90 days following the accident in which the injuries were sustained, the Fund will, subject to the provisions hereafter stated, pay an Accidental Death Benefit of $50,000.

(b) **Accidental Dismemberment Benefits:** If an Eligible Active Employee who sustains bodily injuries solely through external, violent and accidental means, and within 90 days following the accident in which the injuries were sustained, suffers as the result of such injuries one of the losses enumerated below, the Fund will, subject to the provisions hereafter stated, pay to the Eligible Active Employee a Dismemberment Benefit in the following amount:

(1) $10,000 for (a) the loss of a hand by severance at or above the wrist joint, (b) the loss of a foot by severance at or above the ankle joint, or (c) the irrecoverable total loss of sight of one eye.

(2) $5,000 for the loss of the thumb and index finger of the same hand.

(c) **Limitations.**

(1) If the injury causes more than one loss, the insurance will pay only the largest benefit.

(2) No benefits are payable for any loss resulting from bodily injuries sustained as a result of:

(A) Disease or bodily or mental infirmity, or medical or surgical treatment thereof, ptomaine or bacterial infections (except infections occurring through an accidental cut or wound); or

(B) Suicide while sane or insane, or intentionally self-inflicted injury;

(C) War or an act of war, or service in any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization.

(D) Participation in, or as the consequence of having participated in, the committing of a felony or assault.

**Section 3: Beneficiaries.**

(a) **Designation of Beneficiary:** An Eligible Active Employee may designate a Beneficiary or Beneficiaries to receive the Death Benefit or Accidental Death Benefit payable under this Article by forwarding such designation on a form acceptable to the Board of Trustees to the Administrative Office. An Eligible Active Employee shall have the right to change the designation of Beneficiary without consent of the Beneficiary, but no such change shall be effective or binding on the Fund unless the Participant signs a form acceptable to the Board of Trustees prior to the Participant's death and the form is received by the Administrative Office prior to the time any payments are made to the Beneficiary whose designation is on file with the Fund.

(b) If a Participant named a former Spouse as a Beneficiary prior to the dissolution, annulment or invalidation of a marriage, the Beneficiary designation is deemed revoked and null and void as of the date of dissolution, annulment or invalidation of the marriage unless otherwise provided in a divorce decree or other court order pertaining to the dissolution or annulment of the marriage. If more than one Beneficiary is designated, and their respective interests are not specified, they will share alike.

(c) **Lack of Designated Beneficiary:** If no Beneficiary has been designated, or if a designated Beneficiary dies before the Death Benefit or Accidental Death Benefit is paid, the Death Benefit or Accidental Death Benefit shall be paid to the lawful Spouse of the Eligible Active Employee if then living, or if there is no lawful Spouse alive at the time of payment, payment will be made to the first surviving class of the following classes of successive preference Beneficiaries: the Eligible Active Employee's

(1) Surviving children;

(2) Surviving parents;

(3) Surviving brothers and sisters;

(4) Executors or administrators.

If two or more persons are entitled to benefits, they will share equally.

**Section 4: Death Benefit for an Eligible Active Employee's Dependent.**

(a) **Benefit:** Upon the death of a Dependent of an Eligible Active Employee, the Fund will, subject to the provision hereafter stated, pay a Dependent's Death Benefit to the Eligible Active Employee or the Beneficiary, whichever is applicable, in accordance with the following schedule:

| | **Amount of Dependent's Death Benefit** |
|---|---|
| Dependent Spouse | $1,000 |
| Dependent Children age less than 14 days | none |
| Dependent Children age 14 days but less than 6 months | $100 |
| Dependent Children age 6 months but less than 26 years of age | $500 |

(b) **Beneficiary:** The Dependents' Death Benefit will be paid to the Eligible Active Employee, if living. Otherwise, the Dependent's Death Benefit will be payable to the first surviving class of the classes of successive preference Beneficiaries: the Eligible Active Employee's

(1) Surviving Spouse;

(2) Surviving children;

(3) Estate.

If two or more persons are entitled to benefits, they will share equally.

**Section 5: Accident and Sickness Benefit (Non-Occupational Weekly Disability Benefits Only).**

(a) **Definitions:** The term Eligible Active Employee as used in this Section means only those Active Employees eligible for and participating in the Arizona Pipe Trades Plan.

(b) **Benefits:** If an Eligible Active Employee becomes Totally Disabled as a result of sickness or accidental bodily injury, while covered hereunder, the Fund will, subject to the provisions hereinafter set forth, pay to the Eligible Active Employee up to $500 per week. **Payment of Benefits:** Payments begin with the first day of disability due to an accident and the eighth day of disability due to sickness (however, for a sickness for which the Eligible Active Employee is absent from work for more than seven days, payment will be made from the first day of the absence). Payment will continue for the period of disability up to a maximum of 26 weeks for each disability.

(c) **Period of Disability:** Successive periods of disability separated by less than two weeks of continuous active work or availability for work will be considered one period of disability unless the subsequent disability is due to an injury or disease entirely unrelated to the cause of the previous disability and commences after return to active work or availability for work.

(d) **Limitations:** For each day during partial weeks of Total Disability, the Eligible Active Employee will be paid one-seventh of the weekly benefit.

(e) **Exclusions:** The foregoing benefit will not be provided for:

(1) Any period of disability during which the Eligible Active Employee is not under the direct care of a Physician.

(2) Injury or sickness which results from gainful employment.

(f) **To file a request for disability benefits**, obtain a Weekly Disability Statement Of Claim form from the Administrative Office or from the Fund's website at www.azpipe.org. A request for disability benefits must be submitted to the Plan within two years of the date of the onset of the disability. No Plan benefits will be paid for any claim not submitted within this period.

# ARTICLE IV: VISION PLAN BENEFITS AND EXCLUSIONS

**Section 1: Vision Benefits for Active Employees and their Eligible Dependents:**

| Vision plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the Patient Protection and Affordable Care Act (PPACA).<br>Employees may opt out of Vision Plan benefits. |
|---|

(a) Covered benefits are available from an ophthalmologist or an optometrist. There is no Vision plan network.

(b) Covered vision benefits (eye exam and vision supplies) are payable to a **maximum of $500 per person per Calendar Year,** no deductible applies. Vision benefits include:

- Eye examinations, no more than once within a Calendar Year period;
- Lenses, no more than once within a Calendar Year period;
- Frames, no more than once within a Calendar Year period;
- Contact lenses, no more than once within a Calendar Year period or one year supply of disposable contacts to the benefit maximum;
- Prescription safety glasses and goggles for Active Employees only. This benefit allows up to an additional $200/Active Employee every 24 months toward frames, lenses and add-ons for prescription safety glasses and goggles; and
- Prescription sunglasses.

(c) No benefits are payable for:

- Non-prescription sunglasses.
- Safety glasses or goggles (except that prescription safety glasses or goggles will be covered for Active Employees only instead of glasses or contacts).
- Medical or surgical treatment of eyes which would normally be covered under the Medical Plan.
- Services or materials provided as a result of any Workers' Compensation law, or similar legislation, or obtained through or required by a government agency or program whether Federal, State or any subdivision thereof.
- Expenses for which payment is made under any other benefit provided by the Plan other than this vision benefit.
- Orthoptics (vision training to improve the visual perception and coordination of the two eyes), subnormal vision aids and any associated supplemental testing.
- Glasses secured when there is no prescription issued by an ophthalmologist or optometrist, such as reading glasses obtained from a drugstore.

**Section 2: Vision and/or Dental benefits for the eligible Early Retiree and his/her Spouse.**

| Vision plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the Patient Protection and Affordable Care Act (PPACA).<br>Retirees may opt out of Vision Plan and/or Dental Plan benefits. |
|---|

(a) Expenses associated with any vision and/or dental care are payable to a **maximum of $300** per person per Calendar Year. There is no vision or dental network.

(b) This Vision and/or Dental benefits are not available to Dependent Children.

(c) This Vision and/or Dental benefits are not available to an Early Retiree who is under age 55 on the date of his/her retirement or his/her Spouse.

(d) To be reimbursed for vision and/or dental care, send the bill or receipt along with the following information to the Administrative Office within two years of receiving the care:

- The date service(s) were received;
- The type and cost of service(s) you received; and

- The date you paid the provider for the service(s) you received.

**Section 3: Limitations and Exclusions**

In addition to the exclusions noted earlier in this Article, the following is a list of services and supplies or expenses not covered by the Medical, Dental or Vision Plans. The Board of Trustees and their designees will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Benefits will not be payable for:

(a) **Workers compensation, third-party exclusions:**

(1) Any accidental bodily injury arising out of, or in the course of, an Eligible Individual's employment or in connection with any illness, injury or disease for which the Eligible Individual is entitled to indemnity in accordance with the provisions of any **workers' compensation**, occupational disease or similar law, (except as provided for under the Death Benefit and Accidental Death and Dismemberment benefit).

(2) If the responsible third-party and/or its insurer deny a claim or otherwise contest the application of workers' compensation or similar laws for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to the right to reimbursement provided for in Article VIII on Coordination of Benefits, if and when it is determined that they are covered under workers' compensation, occupational disease or similar laws. The Plan will also be subject to reimbursement if an Eligible Individual enters into a lump sum or other settlement agreement, even if the responsible third-party, its insurer and the Eligible Individual stipulate or otherwise agree that the injury or illness was not subject to workers' compensation or similar laws. Before any benefit payments are made, the Eligible Individual must execute a reimbursement agreement acceptable to the Board of Trustees.

(3) Any disability subject to coverage by any **worker's compensation** or occupational disease statutes.

(4) Any injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain.

(b) Conditions caused by or arising out of an **act of war, armed invasion or aggression**;

(c) Any supplies or services (1) **for which no charge is made**; or (2) for which the Eligible Individual is not required to pay, or (3) furnished by a Hospital or facility operated by the United States Government or any authorized agency thereof or furnished at the expense of such Government or agency; or (4) which are provided without cost by any federal, state, municipal, county, or other political subdivision; (5) treatment in a United States government Hospital, or elsewhere, at federal government expense unless required by law.

(d) Medical services or supplies not reasonably **Medically Necessary** for the care or treatment of bodily injuries or sickness or for dental services or supplies not reasonably necessary for dental health.

(e) Services, treatments or supplies for the care and treatment of bodily injuries or sicknesses which are in **excess of the Allowed Charges** thereof or in excess of such charges as would have been made for such care and treatment in the absence of the benefits provided by the Fund.

(f) Expenses incurred for **surgical correction of refractive errors** and refractive keratoplasty procedures including, but not limited to, radial keratotomy (RK) and automated keratoplasty (ALK); and Laser In-Situ Keratomileusis (LASIK).

(g) Expense incurred for **cosmetic services** including surgery or medical treatment (including prescription drugs) to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to medical or surgical treatment intended to restore or improve physical appearance.

(h) Expense incurred as a result of the commission or the attempt to commit an assault or felony.

(i) **Experimental or Investigational services**, surgery, supplies, or drugs or medicines and any diagnostic or treatment measures which are considered to be Experimental or Investigational as defined in this Plan.

(j) **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, interest charges, late fees, mileage costs administrative fees, state taxes, state surcharges, interest, or penalties and/or photocopying fees.

(k) **Educational Services:** Even if they are required because of an injury, illness or disability of a covered individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, vision therapy, auditory aides, speech

aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members.

(l) **Expenses for Which a Third-Party Is Responsible:** Expenses for services or supplies for which a third-party is required to pay because of the negligence or other tortious or wrongful act of that third-party. See the Article XI on Subrogation and Reimbursement for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third-party is required to pay for those services or supplies.

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

# ARTICLE V: HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

**Section 1: Establishment of HRA(s).**

This portion of the Plan is designed to permit an Active Employee or a COBRA Participant, or a non-COBRA reduced self-payment Participant, to obtain reimbursement of certain Medical Care Expenses on a nontaxable basis from the Health Reimbursement Arrangement (HRA).

Contributions into an HRA Account will accumulate during your working career (month-to-month and year-to-year) and will be based on the rates negotiated in the applicable Collective Bargaining Agreement. Active employees who were eligible on January 1, 2017, that do NOT have contributions made into an HRA Account under the applicable Collective Bargaining Agreement, will have a one-time $500 contribution into an HRA Account. HRA benefits are available to a COBRA Participant and a non-COBRA reduced self-payment Employee. HRA benefits are also available to Active Employees or their Dependents for only these two reasons:

- The individual enrolled in the Fund's Medical Plan, requests reimbursement for their Medical Plan deductible up to a maximum annual amount reimbursable by the HRA of $1,500 per family.
- The individual meets the Emergency Provisions discussed in Section 3(a) in this Article.

Any remaining HRA contributions will be transitioned to the Retiree Only HRA Account when the HRA Participant becomes a Non-Medicare Retiree or a Medicare-eligible Retiree.

(a) **Legal Status.**

This Plan is intended to qualify as an employer-provided medical (health) reimbursement plan under Code §105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Plan is intended to comply with the requirements of IRS Notice 2013-54 and shall be interpreted to accomplish that objective. The Medical Care Expenses for an emergency situation, COBRA premiums, or non-COBRA reduced self-payments and reimbursed medical expenses subject to the deductible are intended to be eligible for exclusion from participating Active Employee's or COBRA Participant's gross income under Code §105(b).

Benefits under this Plan are not vested and may be changed or terminated at the discretion of the Board of Trustees.

(b) **Definitions.**

(1) **"Code"** means the Internal Revenue Code of 1986, as amended.

(2) **"Health FSA"** means a health flexible spending arrangement as defined in Proposed Treasury Regulations §1.125-2, Q/A-7(a).

(3) **"Highly Compensated Individual"** means an individual defined under Code §105(h), as amended, as a "highly compensated individual."

(4) **"HRA"** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

(5) **"HRA Account"** means the account described in this Article.

(6) **"HRA Participant"** means a person who is an Active Employee, a COBRA Participant, or a non-COBRA reduced self-payment Participant, for whom the required HRA contributions have been negotiated and paid. The Active Employee must be actually enrolled in a group health plan that provides minimum value pursuant to Internal Revenue Code §36(c)(2)(C)(ii), regardless of whether the group health plan is sponsored by this health and welfare fund. If a Spouse or Dependent Child are not enrolled in any group health plan, the HRA cannot reimburse their expenses.

(A) Proof of other group health plan coverage will be required in a manner to be determined by the Trustees. If proof is not provided, benefits will be restricted to reimbursement of copayments, coinsurance, deductibles, premiums under the other group health plan coverage and medical care as defined under IRC Section 213(d) that does not constitute essential health benefits.

(B) A group health plan provides minimum value if the coverage has an actuarial value of at least 60% under standards determined by the IRS or meets the IRS approved alternate reimbursement provision for plans that do not meet minimum value.

(7) **"Medical Care Expenses"** means

(A) medical care expenses including, but not limited to, COBRA premiums and non-COBRA reduced self-payments; and

(B) medical care expenses for COBRA Participants and for surviving spouses and surviving dependent children; and

(C) medical care expenses that meet the definition of "medical care" under Internal Revenue Code §213, except those expenses that are excluded under Section 8 of this Article; and

(D) medical care expenses incurred by an Active Employee or his/her Dependents for an emergency situation as defined under Section 3(a) in this Article, and which are medical care expenses eligible for reimbursement pursuant to Code §105 and 213(d) (including, for example, amounts for certain bills for Hospital care, doctors, dental care, vision care and prescription drugs and includes medical expenses paid toward a Medical Plan deductible), but does not include expenses that are described in Section 8 of this Article.

Reimbursements due for Medical Care Expenses incurred by the HRA Participant or the HRA Participant's Dependents shall be charged against the HRA Participant's HRA Account.

(8) **"Period of Coverage"** means the period of time the individual is an eligible HRA Participant.

**Section 2: Benefits Offered and Method of Funding.**

(a) **Benefits Offered**. When an Active Employee or COBRA Participant becomes an HRA Participant, an HRA Account will be established for such HRA Participant to receive contributions actually made with respect to his/her employment for the purpose of providing benefits in the form of reimbursements for:

(1) COBRA premiums and non-COBRA reduced self-payment Participants, as described in Section 3;

(2) For COBRA Participants and non-COBRA reduced self-payment Participants medical care expenses under IRC Section 213, except those expenses excluded under Section 8 of this Article;

(3) Medical care expenses that meet the definition of "medical care" under Internal Revenue Code §213, except those expenses excluded under Section 8 of this Article; and

(4) For Active Employees and their Dependents: certain emergency situation Medical Care Expenses (defined below), in accordance with medical care expenses under IRC Section 213, except those expenses excluded under Section 8 of this Article.

Benefits will be provided up to the unused amount in the HRA Participant's HRA Account, as set forth and adjusted under Section 3(e) below, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees.

In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. The HRA Participant's HRA Account shall not accrue interest.

(b) **Employer and HRA Participant Contributions.**

(1) **Employer Contributions**. The Contributing Employer will submit the contributions in accordance with its legal obligations. If no contributions have been made with respect to the individual's employment the individual will not become an HRA Participant.

(2) **HRA Participant Contributions**. There are no HRA Participant contributions for benefits under the Plan.

(c) **No Funding Under Cafeteria Plan**. Under no circumstances will the benefits be funded with salary reduction contributions, employer contributions (*e.g.*, flex credits) or otherwise under a cafeteria plan.

**Section 3: HRA Benefits.**

(a) **Benefits.** The Plan will reimburse the following HRA benefit expenses:

(1) COBRA premiums and non-COBRA reduced self-payments;

(2) For COBRA Participants and non-COBRA reduced self-payment Participants, medical care expenses under IRC Section 213, except those expenses excluded under Section 8 of this Article;

(3) Medical care expenses that meet the definition of "medical care" under Internal Revenue Code §213, except those expenses excluded under Section 8 of this Article; and

(4) For Active Employees and their Dependents: certain emergency situation Medical Care Expenses (defined below), in accordance with medical care expenses under IRC Section 213, except those expenses excluded under Section 8 of this Article.

Benefits will be provided up to the unused amount in the HRA Participant's HRA Account, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees.

**Emergency Provisions for an Active Employee and his or her Dependents**:

The use of accumulated HRA funds by an Active Employee to pay for Medical Care Expenses of that Active Employee or his/her Dependents will be permitted **in an emergency situation**, which is properly documented and approved by the Plan. An "**emergency situation"** is one in which the Active Employee or his/her Dependents **are required to pay deductibles/copays/coinsurance in advance of receiving urgent medical treatment or services**. The HRA funds must be used for reimbursement of the Active Employee's or his/her Dependent's Medical Care Expenses (in accordance with Code §105 and 213(d)) and this Plan. Contact the Administrative Office for details.

(b) **Medical Care Expenses and How to File a Claim for HRA benefits**. An HRA Participant may receive reimbursement for eligible Medical Care Expenses (as defined in Section 1(b)(7)), provided a claim for such benefits is made as prescribed by the Board of Trustees and there are adequate funds in the HRA to reimburse part or all of such claim. An HRA Reimbursement Request form is available from the Administrative Office.

(1) **Incurred**. Except when it is an "emergency situation" as defined above, a Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before an HRA Participant first becomes covered by the Plan are not eligible.

However, a Medical Care Expense incurred during one Plan Year may be paid during a later Plan Year, provided that the HRA claim was submitted timely.

(2) **How to File a Claim for HRA benefits**. Claims for HRA benefits may be made by using your benefit reimbursement card or filing an HRA Reimbursement Request form with the Administrative Office. HRA Reimbursement Request forms are available from the Administrative Office or the Fund's website. Claims for HRA benefits must be submitted within two years from the date of service.

(3) **Medical Care Expenses Exclusions.** "Medical Care Expenses" shall not include the expenses listed as exclusions under Section 8 of this Article.

(4) **Cannot Be Reimbursed or Reimbursable from Another Source**. Medical Care Expenses can only be reimbursed to the extent that the Active Employee or his/her Dependents incurring the expense is not reimbursed for the expense through the Medical Plan, other insurance, or any other accident or health plan (if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (*e.g.*, because the Plan imposes Copayment or Deductible limitations), the HRA can reimburse the remaining portion of such expense if it otherwise meets the requirements herein.

(c) **Maximum Benefits**. There will not be a maximum dollar amount that may be credited to an HRA Account for an Active Employee or COBRA Participant. Unused amounts in the HRA Account may be carried over to the next year, as provided hereafter.

(d) **Nondiscrimination**. Internal Revenue Code §105(h) applies to this Plan.

(e) **Establishment of Account**. The Administrative Office will establish and maintain an HRA Account with respect to each HRA Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping contributions and available reimbursement amounts. Any earnings from the contributions will be pooled to pay administrative expenses. The Board of Trustees retains discretion to determine the manner in which HRA Accounts shall be credited.

(1) **Crediting of HRA Accounts**. An HRA Participant's HRA Account will be credited when actual contributions are received. The Plan Administrator or its designee shall calculate the amount to be

credited to each HRA Participant's HRA Account pursuant to Section 2 of this Article, and shall notify them as to the total available in the HRA Account.

(2) **Debiting of HRA Accounts**. An HRA Participant's HRA Account will be debited for any reimbursement of Medical Care Expenses.

(3) **Available Amount**. The amount available for reimbursement of Medical Care Expenses (as defined in Section 1(b)(7)) of this Article is the amount credited to the HRA Participant's HRA Account as described above reduced by prior reimbursements debited as described above.

(f) **Carryover of Accounts.** If any balance remains in the HRA Participant's HRA Account at the end of a Plan Year after all reimbursements have been made, such balance shall be carried over to reimburse the HRA Participant for eligible Medical Care Expenses incurred during a subsequent Plan Year.

(g) **Opt Out or Freeze Permitted.**

(1) **Opt Out**. An HRA Participant is permitted to permanently opt out of the HRA which will forfeit the unused HRA Account balance. By opting out of HRA coverage (which is considered to be group coverage), an individual may preserve his/her eligibility to qualify for a federal premium assistance tax credit (a subsidy) to buy insurance coverage in the Health Insurance Marketplace. Participants who permanently opt out of the HRA plan will:

(A) Waive all rights to future HRA Plan reimbursements;

(B) Not be eligible for reinstatement in this HRA Plan at any time in the future; and

(C) Will not be eligible for COBRA continuation coverage.

This opt out election is available at least annually and upon termination of coverage under the Plan. For the process to opt out, contact the Administrative Office.

(2) **Freeze Unused HRA Account Balance For Use at a Later Date.** An HRA Participant is permitted to request to freeze (meaning suspend or temporarily opt out of the HRA) their unused HRA Account balance once per calendar year, in a time and manner determined by the Trustees. By freezing the unused HRA balance (which is considered to be group coverage), an individual may preserve his/her eligibility to qualify for a federal premium assistance tax credit (a subsidy) to buy insurance coverage in the Health Insurance Marketplace.

A frozen HRA Account balance can be reinstated upon the Participant's requested date or the Participant's date of death.

(A) An election must be made prior to the effective date of the freeze and is irrevocable until a reinstatement event occurs.

(B) Reinstatement Event. You may be reinstated in your HRA, and the balance unfrozen, upon the earlier of the following events:

(i) The first day of the calendar year following the year for which a Participant elected to freeze their unused HRA Account balance and the Participant notifies the Fund of this request;

(ii) The date upon which the Participant becomes eligible for and enrolled in Medicare parts A and B; or

(iii) The Participant's date of death.

(C) Contact the Administrative Office for the form to request that an HRA Account balance be frozen on a selected date, or the form to request that the HRA Account balance be reinstated on a selected date.

(D) Participants, eligible Spouses and eligible Dependents may not have access to the HRA Account balance after the effective date of the freeze. Upon reinstatement, the Plan cannot reimburse any Medical Care Expenses incurred after the effective date of the freeze and before the reinstatement. However, after the reinstatement event, access to the HRA Account balance is available for Medical Care Expenses incurred after the reinstatement event and which are submitted to the Administrative Office in a timely manner.

(3) Non-Medicare Eligible Individuals with certain household income levels who purchase individual coverage through a Health Insurance Marketplace may be eligible for federal subsidies to help them pay the insurance premiums. Individuals who are covered under a group health plan, including an HRA, are not eligible for these subsidies. Therefore, some individuals may request to permanently opt out of or temporarily freeze their HRA Account balance in order to qualify for a subsidy.

**Section 4: Reimbursement Procedure.**

(a) **Benefit Reimbursement Card.** HRA Participants may access their HRA Account by using a prepaid debit card consistent with procedures adopted by the Board of Trustees. HRA Participants will receive two prepaid debit cards at their home address for their use and the use of their eligible dependents. The cards will be loaded with the value of the Participant's HRA Account as it becomes available and will automatically deduct the amount of eligible Medical Care Expenses purchased. To use the card, simply swipe the card each time you incur a qualified health care expense, and the amount of the purchase will automatically be deducted from the HRA Account. It is also possible to fill in the card number on bills received from providers to pay the amount owed. Using the card means that there are generally no claim forms to complete and no wait to get a reimbursement check in the mail. HRA Account balances and details can be checked online through the WEX Health Participant Portal (my.wexhealthcard.com).

The IRS requires the card be used only for eligible medical care expenses, so the card will not work at gas stations or restaurants – only at health care-related providers. Most of the time, the swipe of the card automatically allows the verification of the eligibility of the expense being purchased. However, in certain situations, the HRA Participant may receive a request for an itemized receipt to verify the expense. Receipts must be submitted as soon as possible to avoid suspension of the card.

For additional information on the benefit reimbursement card, please refer to the FAQ Documents posted on the Fund's website or contact the Administrative Office.

(b) **Timing of Reimbursement Claims**. Within 30 days after receipt by the Administrative Office of a reimbursement claim from an HRA Participant, the Administrative Office will reimburse the HRA Participant for appropriate Medical Care Expenses, or the Administrative Office will notify the HRA Participant that his/her claim has been denied.

This time period may be extended for an additional 15 days for matters beyond the control of the Administrative Office, including in cases where a reimbursement claim is incomplete. The Administrative Office will provide written notice of any extension, including the reasons for the extension, and will allow the HRA Participant 45 days in which to complete an incomplete reimbursement claim.

(c) **Claims Substantiation**. An HRA Participant who seeks benefits may apply for reimbursement by submitting an application, called an HRA Reimbursement Request, in writing to the Administrative Office in such form as the Board of Trustees may prescribe, but **no later than two years from the date of service** on the claim, setting forth:

(1) The person or persons on whose behalf Medical Care Expenses have been incurred;

(2) The nature and date of the Medical Care Expenses so incurred;

(3) The amount of the requested reimbursement; and

(4) A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted. The application shall be accompanied by bills, invoices, or other statements from an independent third-party showing that the Medical Care Expenses have been incurred, payment is due and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrative Office may request. No claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least **$250**.

(5) The Board of Trustees may waive the time deadline of two years from the date of service on the claim for good cause.

(d) **Claims Denied**. For reimbursement claims that are denied, see the appeals procedure in Article VII on Claim Filing and Appeals Procedures.

**Section 5: Reimbursements After Termination and COBRA/Self-Payment.**

(a) When an HRA Participant ceases to be an HRA Participant hereunder, the HRA Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his/her participation terminates. Such HRA Participant (or the HRA Participant's estate) may claim reimbursement for any Medical Care Expenses incurred prior to termination of participation, provided that the HRA Participant (or the HRA Participant's estate) files a claim within **two years** from the date of service on the claim. Reimbursement is only permitted if and to the extent:

(1) The claim is an eligible Medical Care Expense;

(2) There are funds in the HRA Account;

(3) The Participant was HRA-eligible when the claim was incurred;

(4) The Participant has not submitted the claimed Medical Care Expenses as a deduction on any federal income tax return; and

(5) The Participant has not been reimbursed for such Medical Care Expense from another source or plan.

(b) An HRA Participant and his/her Spouse and Dependents (who are Qualified Beneficiaries) whose coverage terminates under the HRA Account because of a COBRA qualifying event will be given the opportunity to temporarily continue (on a self-pay basis) the same coverage that her or she had under the HRA Account on the day before the qualifying event for the period of time specified by COBRA. This includes that Qualified Beneficiaries will be credited with the HRA contributions made available to similarly situated non-COBRA Beneficiaries. Note that COBRA is not available to individuals who have permanently opted out of HRA coverage. Refer to Article II in this document.

(c) A COBRA-eligible HRA Participant shall not be eligible for reimbursement under the HRA after COBRA coverage terminates.

**Section 6: Recordkeeping and Administration.**

(a) **Inability to Locate Payee**. If the Administrative Office is unable to make payment to any HRA Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such HRA Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such HRA Participant or other person shall be subject to the provisions set forth in Section 6(d).

(b) **Effect of Mistake**. In the event of a mistake as to the eligibility or participation, or the allocations made to the HRA Account of any HRA Participant, or the amount of benefits paid or to be paid to an HRA Participant or other person, the Administrative Office shall, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such HRA Participant or other person the credits to the HRA Account or distributions to which he/she is properly entitled under the Plan. Such action by the Administrative Office may include withholding of any amounts due to the Plan from any future benefits.

(c) **Account Forfeiture.** Any HRA Account for an individual that ceases to be an Active Employee that remains inactive (no money coming in or money going out) for 24 consecutive months, will be forfeited and the HRA Account will be closed.

Any HRA Account of an HRA Participant that:

(1) Takes employment in Arizona in any capacity or continues employment in Arizona in any capacity with any employer in the plumbing and pipefitting industry not obligated to contribute to the Arizona Pipe Trades Health and Welfare Trust Fund; or

(2) Engages in any kind of commercial business activity in the plumbing and pipefitting industry in Arizona as a sole proprietor, partner, contractor or commission agent without being signatory to a labor agreement with Local 469 requiring contributions to the Arizona Pipe Trades Health and Welfare Trust Fund;

will be forfeited and the HRA Account will be closed. Remaining HRA Account balances will revert to general Fund reserve assets.

(d) **Reinstatement of HRA Account Balance**: Generally, if an individual ceases to be an Active Employee and is not yet a Retiree and returns to work through Local 469, his/her HRA Account balance will be reinstated at the level that existed at the time of forfeiture. Additionally, if an Active Employee with an HRA Account ceases to be an Active Employee and is not yet a Retiree, the HRA account balance will be reinstated to that person when they become a Retiree in the Retiree Only HRA Plan at the level that existed at the time of the forfeiture. Reinstatement is not permitted if: (i) the individual permanently opted out and forfeited the unused balance; (ii) the balance was transferred to the Retiree in the Retiree Only HRA Plan; or (iii) the HRA Account was forfeited and closed due to prohibited employment described in Section 6(c) of this Article.

(e) **Termination of HRA Account.** An Active Employee or a COBRA Participant will cease to be a Participant in this Plan upon the earlier of:

(1) The date on which this Plan is terminated;

(2) The date the HRA Account is forfeited or suspended as outlined above;

(3) The date the employee becomes a retiree under the eligibility provisions of the Retiree Only HRA Plan;

(4) The effective date of the election to permanently opt-out of coverage under this HRA Plan; or

(5) The date on which the HRA Participant's HRA Account reaches a zero balance.

(f) **Opt-Out**. An Active Employee is permitted to permanently opt-out of the HRA which will forfeit the unused HRA Account balance. By opting out of HRA coverage (which is considered to be group coverage), an individual may preserve his/her eligibility to qualify for a federal premium assistance tax credit (a subsidy) to buy insurance coverage in the Health Insurance Marketplace. This opt-out election is available at least annually and upon termination of coverage under the Arizona Pipe Trades Health and Welfare Trust Fund. For the process to opt-out, contact the Administrative Office.

Participants who permanently opt-out of the HRA Plan will:

(1) Waive all rights to future HRA Plan contributions and HRA Plan reimbursements;

(2) Not be eligible for reinstatement in this HRA Plan at any time in the future; and

(3) Will not be eligible for COBRA continuation coverage for the HRA.

(g) **Participation Following Death of an HRA Participant.** In the event of an HRA Participant's death, the surviving Spouse and tax-qualified Dependents (who were covered at the time of the Participant's death) may continue to submit eligible Medical Care Expenses to the HRA until the earlier of:

(1) Such time as the balance in the HRA Participant's HRA Account reaches zero; or

(2) The date the HRA Account is otherwise terminated as outlined above.

(h) **Effect of Divorce.** In the event of the HRA Participant's divorce, the HRA Account is not marital property and may not be used to reimburse medical expenses for an ex-Spouse otherwise ineligible under the Plan.

**Section 7: No Guarantee of Tax Consequences.**

(a) Neither the Administrative Office nor the Board of Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of an HRA Participant under this portion of the Plan will be excludable from the HRA Participant's taxable income for federal, state, or local income tax purposes.

It shall be the obligation of each HRA Participant to determine whether each payment under this portion of the Plan is excludable from the HRA Participant's gross income for federal, state, and local income tax purposes, and to notify the Administrative Office if the HRA Participant has any reason to believe that such payment is not so excludable.

**Section 8: Exclusions - Medical Expenses That <u>Are Not</u> Reimbursable from an HRA Account Under this Plan**

(a) This Section specifies certain expenses that **<u>are not reimbursable</u>** from an HRA Participant's HRA Account because they do not meet the definition of "medical care" under Internal Revenue Code §213 or are not considered to be reimbursable by this Plan. The following expenses are not reimbursable:

(1) Health insurance premiums for coverage that has been reimbursed under a Spouse's plan (*e.g.*, coverage subject to the "double-dip" prohibitions of Revenue Ruling 2002-3).

(2) Premiums for individual health insurance (whether purchased in the individual insurance marketplace, private exchange, or public exchange such as in state or federal Health Insurance Marketplace), Premiums for group health insurance coverage, Long Term Care Insurances and Medicare.

(3) Long-term care services.

(4) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

(5) Cosmetic dental services.

(6) The salary expense of a nurse to care for a healthy newborn at home.

(7) Funeral and burial expenses.

(8) Household and domestic help (even though recommended by a qualified Physician due to the Active Employee’s or Dependent’s inability to perform physical housework).

(9) Massage therapy (unless it qualifies as a medical expense).

(10) Home or automobile improvements. (These are potentially qualifying expenses if they are done to accommodate a disability.)

(11) Custodial care.

(12) Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods (unless it is a residential school or program to treat behavioral, emotional and/or addictive conditions and the primary purpose of the program is medical care).

(13) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity (unless the expense would not have been incurred but for the disease).

(14) Social activities, such as dance lessons (even though recommended by a Physician for general health improvement). These are potentially qualifying expenses if they are recommended by a Physician to treat a medical condition such as rehabilitation after surgery.

(15) Bottled water.

(16) Diaper service or diapers.

(17) Cosmetics, toiletries, toothpaste, etc.

(18) Vitamins and food supplements, even if prescribed by a Physician. (Potentially a qualifying expense if recommended by a Physician for a specific medical condition).

(19) Uniforms or special clothing, such as maternity clothing.

(20) Automobile insurance premiums.

(21) Transportation expenses of any sort, including transportation expenses to receive medical care. (This is potentially a qualifying expense if the expense is primarily for and essential to medical care).

(22) Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a Physician.

(23) Any item that does not constitute “medical care” as defined under Code §213.

(24) Medical care expenses covered by the Medical Plan but not subject to the Medical Plan deductible.

# ARTICLE VI: DENTAL PPO BENEFITS FOR ELIGIBLE INDIVIDUALS

**Section 1: Overview.**

| Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the Patient Protection and Affordable Care Act (PPACA).<br>Employees may opt out of Dental Plan benefits. |
|---|

This Article outlines the benefits of the self-funded Dental PPO Plan coverage.

**Benefits-eligible Active Employees will automatically be enrolled for Dental PPO Plan benefits.**

**Dental PPO Network:** The Fund has entered into an agreement with an independent Dental PPO Network whose name and phone number is listed on the Quick Reference Chart in the front of this document. This Dental PPO Network (also called a PPO Network) contracts with Dentists who are located in Arizona. Under the Dental PPO Network arrangement, contracted Dental PPO Network providers charge a cost that is significantly less than their regular fees.

While you do not have to use A Dental PPO Network provider, using Dental PPO Network providers will save you and the Fund money. This is because you will pay your Participant Coinsurance based on the discounted amount rather than on the non-discounted amount. Also, Preventive dental benefits (as described under Section 4 of this Article) are provided at no cost when you use Dental PPO and Premier Network providers.

Out-of-Network providers do not offer discounted fees to you or the Fund and they can also bill you for any balance that is due in addition to the amount that was payable by the Fund (called "Balance Billing"). Network providers are prohibited (by their contract with the Dental PPO Network) from billing you for differences between their normal fees and the amount that is considered an Allowed Charge by this Plan.

**Section 2: Definitions**

(a) **Eligible Individual:** The term "**Eligible Individual"** as used in this Article means those individuals eligible for and participating in the Arizona Pipe Trades Plan, except that an Early Retiree and his or her Dependents cannot elect the Dental PPO Plan coverage.

(b) **Covered Dental Expense:** For an Out-of-Network provider, the term "Covered Dental Expense" means only expenses incurred for necessary treatment received by an Eligible Individual from a Dentist, which, in the geographical area where treatment is rendered, is the Allowed Charge for the procedure of the condition being treated. However, the amount considered as Covered Dental Expense shall not exceed the Allowed Charge for the treatment generally furnished for cases of comparable nature and severity in such geographical area.

For a Network dental provider (licensed Dentists and dental hygienists), the "Covered Dental Expense" will be the discounted fee according to the contract between the provider and the Dental PPO Network.

(c) **Dental Deductible:** The term "Dental Deductible", with respect to Covered Dental Expenses incurred by each Eligible Individual **is $25 per person and $50 per family (of two or more persons) each Calendar Year.**

The Dental Deductible applies separately to each Eligible Individual once during each Calendar Year. However, if the Dental Deductible has been satisfied by two or more Eligible Individuals of the same Eligible Employee's family during any Calendar Year, Covered Dental Expense incurred by any other Eligible Individual whose coverage arises from the same Eligible Employee will not be subject to the Dental Deductible during the remainder of the Calendar Year.

The Dental Deductible will be waived for all Preventive dental services described under Section 4 of this Article.

**Section 3: Dental PPO Plan Benefits**

(a) **Coinsurance:** If an Eligible Individual incurs necessary (non-preventive) Covered Dental Expenses which exceeds the Dental Deductible, the Fund will, subject to the terms and conditions hereafter stated, pay an amount equal to 80% of all such expenses which are in excess of the Dental Deductible.

- If a PPO or Premier network dental provider is used the Plan pays 80% of the **Network provider's discounted fee** (discounted fee is determined by the Dental Plan claims administrator as the lesser of billed charges or the PPO dentist's allowable fee or the Premier dentist's Maximum Reimbursement Amount) and the Eligible Individual pays 20%.

- If a Non-Network dental provider is used the Plan pays 80% of the Plan's Allowed Charge (defined as the lesser of billed charges or the fee listed on the Dental Network's non-participating dentist table of allowance) and the Eligible Individual pays 20% of the Plan's Allowed Charge, plus the Eligible Individual could be billed for the difference between the provider's billed charges and the Dental Plan's Allowed Charge amount (referred to as balance billing).

(b) **Annual Dental Benefit Maximum**: The maximum aggregate amount payable for dental services rendered to each Eligible Individual in any one Calendar Year shall be $3,000.

(c) **Preventive Dental Benefits**: If a PPO or Premier network dental provider is used the Plan pays **100% of the Network provider's discounted fee** (defined in (a) above) with no deductible. Out-of-network providers paid at 80% coinsurance (with no deductible). Preventive dental benefits are described under Section 4 of this Article.

**Section 4: Schedule of Dental PPO Plan Services**

Subject to the Limitations and Exclusions hereinafter contained in Section 5 of this Article, the following is the Schedule of Dental Services covered hereunder when rendered by a Dentist and when necessary and an Allowed Charge, as determined by the Dental Plan Claims Administrator.

Predetermination (from the Dental Plan Claims Administrator) is recommended for dental services over $250.

(a) **Preventive Dental Benefits**:

(1) **Diagnostic** - Procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment.

(2) **Preventive** - Includes the following services:

- **Routine prophylaxis (cleaning)** two times per year. Difficult cleanings may be exchanged for a routine cleaning with no limits.
- **Routine dental exams, evaluations, or** consultations two times per year.
- Two topical applications of **fluoride** for adults and children per year.
- **Space maintainers** for adults and children, as needed. Not covered for Ortho.

*Preventive services obtained from PPO and Premier Network providers are paid at 100% coinsurance and are not subject to the Dental Deductible. Out-of-network providers paid at 80% coinsurance and are not subject to the Dental Deductible.*

(b) **Basic Services** (after Dental Deductible met)

(1) **Sealants** are payable for children up to age 19 (all teeth no limits).

(2) **X-rays** (full mouth/panorex, or vertical bitewing or periapical x-rays as needed no limits), **Fillings** (silver amalgam and synthetic tooth color fillings all teeth no limits), **Stainless Steel Crowns** (as needed, no limits), **Emergency (Palliative) treatment** for relief of pain as needed no limits, **Emergency exams** (ADA codes 0140, 0160, 0170 as needed no limits), **Endodontics** (root canal treatment as needed no limits), **Periodontics** (treatment of gum disease surgical or non-surgical as needed no limits), **Periodontal maintenance** (as needed no limits), **Oral surgery** (simple and surgical extractions).

*Basic services obtained from PPO and Premier Network providers are paid at 80% coinsurance after Dental Deductible met. Out-of-network providers paid at 80% coinsurance after Dental Deductible met.*

(c) **Major Services** (after Dental Deductible met)

(1) Prosthodontics**,** bridges, partial dentures, complete dentures – five-year waiting period for replacement last performed no limits), Bridge and denture repair (repair of such appliances to their original condition including relining of dentures), Implants and implant related procedures (as needed no limits and is applied to the patient's annual maximum benefit), Interim partial stayplates (flipper – all teeth no limits), Occlusal guards, night guards or bite guards (covered once), and Restorative crowns, inlays, onlays, gold restorations, veneers (as an alternative benefit of crown provided, five-year waiting period for replacement last performed, as needed no limit).

*Major services obtained from PPO and Premier Network providers are paid at 80% coinsurance after Dental Deductible met. Out-of-network providers paid at 80% coinsurance after Dental Deductible met.*

(d) Certain outpatient prescription drugs used for a Dental Purpose (*e.g.*, antibiotic, pain medication) are payable under the Medical Plan's outpatient prescription drug benefit.

**Section 5: Limitations and Exclusions of the Dental PPO Plan:**

Benefits will **not** be payable for:

(a) Oral examinations and prophylaxis more than two visits per Calendar Year.

(b) **Replacement of an existing denture** which, in the opinion of the attending Dentist, is or can be made satisfactory; or, expense incurred for a temporary full denture; or, expense incurred for the replacement of a denture for which benefits were previously paid under the Fund, if such replacement occurs within five years from the date the expense was incurred for the denture unless

(1) such replacement is made necessary by the initial replacement of an existing full denture or the extraction of natural teeth, or

(2) the denture is a stayplate or a similar temporary partial denture, and is being replaced by a permanent denture, or

(3) the denture, while in the oral cavity, has been damaged beyond repair.

(c) Expense incurred for any dental procedure performed for **cosmetic reasons**.

(d) Expense incurred for **any procedure that commenced prior to the date the patient became an Eligible Individual**, or any supplies furnished in connection with such procedure, except that for purposes of Exclusions, x-rays and prophylaxis treatment shall not be deemed to commence prior to a dental procedure.

(e) Expense incurred for **orthodontics**.

(f) Expense incurred for replacement of a lost or stolen appliance.

(g) Expense for services received by any Eligible Individual which are performed by a member of the **immediate family** of the Eligible Individual.

(h) Expense incurred for which payment is made under any other provisions of the Plan.

(i) Expenses incurred for the treatment of temporomandibular joint (TMJ) dysfunction/disorders.

(j) A **gold crown or other gold restoration in excess of** the amount payable for an amalgam restoration, except when required to restore a tooth to its proper contour and there is no other reasonable means of restoring the contour of the tooth.

(k) **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls, interest charges, late fees and/or photocopying fees.

(l) **Expenses for Which a Third-Party Is Responsible:** Expenses for services or supplies for which a third-party is required to pay because of the negligence or other tortious or wrongful act of that third-party. See Article XI on Subrogation and Reimbursement for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third-party is required to pay for those services or supplies.

(m) **Experimental and/or Investigational Services:** Expenses for any dental services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in Article I on General Definitions in this document.

(n) **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in Article I on General Definitions in this document.

(o) **Non-Dentist:** Expenses for services rendered or supplies provided that are **not recommended or prescribed by a Dentist.**

(p) **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if you or your covered Dependent were

not covered by workers' compensation insurance, or if the covered individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified.

(q) **Services Provided Outside the United States:** Expenses for dental services or supplies rendered or provided outside the United States, except for treatment for an Emergency as defined in Article I on General Definitions in this document.

(r) **Analgesia, Sedation, Hypnosis, etc.:** Expenses for analgesia, sedation, hypnosis and/or related services provided for apprehension or anxiety (except: (1) in connection with covered extractions or oral surgery; or (2) for children seven years and younger who have more than one basic and/or major dental procedure in one day (limited to up to one hour of IV sedation, general anesthesia, or nitrous oxide) as determined medically necessary by the provider).

(s) **Cosmetic Services:** Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to bleaching of teeth, veneers, facings enamel hypoplasia (lack of development), fluorosis (tooth discoloration) and anodontia (congenitally missing tooth). However, the following will be covered if they otherwise qualify as covered dental expenses and **are not covered** under your Medical Expense Coverage:

- Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
- Surgery or treatment to correct deformities caused by sickness;
- Surgery or treatment to correct birth defects outside the normal range of human variation;
- Reconstructive dental surgery because of congenital disease or anomaly of a covered Dependent Child that has resulted in a functional disorder.

(t) **Education Services and Home Use Supplies:** Expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss, etc.

(u) Precision or semi-precision attachments for prosthetic devices. Conventional appliances are payable.

(v) Bacteriologic studies and susceptibility testing for dental caries (cavities) not covered.

(w) **Fees charged for infection control procedures** and compliance with Occupational Safety and Health Administration (OSHA) requirements.

**Section 6: Extended Dental Benefits**

(a) If an Eligible Individual is receiving treatment for services required for the completion of procedures at the time his/her coverage terminates, Dental Benefits will be payable for such services, but not beyond 30 days after termination of coverage. For purposes of this provision, x-rays and prophylaxis treatment shall not be deemed to commence a dental procedure.

If, on the date an individual's coverage hereunder terminates, an Eligible Individual is Totally Disabled as a result of an accident, Dental Benefits will be payable for Covered Dental Expense incurred within three months after termination of coverage for repair or alleviation of damage to natural teeth resulting from such accident, provided the Eligible Individual has remained disabled and the Dental Benefit is in effect on the date the expense is incurred.

# ARTICLE VII: CLAIM FILING AND APPEALS PROCEDURES

**Section 1: How Health Care Benefits Are Paid:**

This Article describes the Plan's claim filing procedures for certain group health benefits under this Plan and for appealing Adverse Benefit Determinations in connection with those claims. Claims covered by these procedures include Dental PPO plan, Vision Plan and Weekly Disability. There are no claims associated with the free (no cost) EAP short-term counseling and referral benefits. The claim appeal process for Medical Plan benefits is explained in Article XV. The claims for the insured Life and Accidental Death and Dismemberment benefits are not addressed in this Article and you should contact the appropriate insurance company for information on appealing an insured claim.

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan Participants. The claim filing procedures outlined in this Article **are designed to afford you a full, fair and fast review of the claim to which it applies**. This Article also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is Experimental or Investigational).

**Section 2: Qualified Medical Child Support Orders (QMCSO)**

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

**Section 3: Benefit Assignment**

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered. A direction to pay a provider is not an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

**Section 4: When You Must Repay Plan Benefits**

If it is found that the Plan benefits paid by the Plan are too much because of any of the following reasons, the Plan may recover pursuant to the methods listed in Subsection (f):

(a) Some or all of the health care expenses were not paid or payable by you or your covered Dependent; or

(b) You or your covered Dependent received the money to pay some or all of those health care expenses from a source other than the Plan; or

(c) You or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third-party (see also Article XI on Subrogation and Reimbursement), regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid; or

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

(e) The Plan erroneously paid benefits because of false information entered on your enrollment form, claims forms or required documentation; or your failure (or your covered Dependent's failure) to promptly advise the administrator of a change of circumstances (such as a divorce) that renders a covered Dependent ineligible.

(f) In the event of an overpayment, the Plan, at the discretion of the Board of Trustees, may pursue any of these remedies:

(1) Recover overpayments from the entity to which the overpayment was made, or on whose behalf it was made; or from the Participant directly;

(2) A refund from you or your Health Care Facility or Health Care Practitioner for the difference between the amount of Plan Benefits actually paid by the Plan for those expenses and the amount of Plan Benefits that should have been paid by the Plan for those expenses based on the actual facts;

(3) Offset future benefits if necessary in order to recover such expenses;

(4) Recover from you the total amount that was overpaid, together with its attorney's fees, costs and expenses incurred in recovering monies that were improperly paid; or

(5) Recover from any former covered Dependent the amount overpaid proximately caused by the former covered Dependent's failure to promptly advise the administrator of a change of circumstances (such as a divorce) that rendered a covered Dependent ineligible.

For additional information on the procedures that may be followed by the Plan to recover these amounts see the provision regarding Acts of Third-Parties in Article XI on Subrogation and Reimbursement.

**Section 5: Time Limit for Filing Dental PPO Plan, Vision Plan, HRA, and Weekly Disability Claims**

- All post-service dental and vision claims must be submitted to the Plan within TWO YEARS from the date of service.
- HRA claims for reimbursement must be submitted to the Plan within TWO YEARS from the date of service.
- Weekly disability claims must be submitted to the Plan within TWO YEARS from the date of onset of the disability.

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

See Article XV for Medical Plan claim filing information.

**Section 6: Additional Information Needed and Coordination of Benefits (COB) Provision**

There may be times during the filing or appeal of a claim that you are requested to submit additional information. If you submit this additional information outside the timeframes outlined to you in the request, the Plan is not legally required to consider that information.

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

**Section 7: When You Must Get Plan Approval In Advance Of Obtaining Health Care**

Some Plan benefits (such as certain drugs) are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this Article and the certification requirements related to the Medical Plan in Article XV.

**Section 8: Definitions**

(a) **Adverse Benefit Determination**: For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination is defined as:

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

(b) **Appropriate Claims Administrator**: means the Claims Administrators for the types of claims outlined in the chart below. See the Quick Reference Chart in the front of this document for the names and addresses of these Claims Administrators.

| Appropriate Claims Administrators | Types of Claims Processed |
|---|---|
| Medical Plan Claims Administrator | • Medical Plan post-service claims and Level One post-service claim appeals |
| Administrative Office | • Medical Plan Level Two post-service claim appeals<br>• Dental PPO Plan and Vision Plan post-service claims and Level One (Administrative Office) and Level Two claim appeals (Board of Trustees)<br>• Weekly Disability post-service claims and appeals<br>• HRA post-service claims and Level One and Level Two claim appeals |
| Utilization Management Program (administered by the Medical Plan Claims Administrator) | • Urgent, concurrent, and pre-service claims and appeals. |
| Prescription Benefit Manager (PBM) | • Post-service claims for Out-of-Network retail drugs under the direct member reimbursement program and Level One appeals.<br>• Certain pre-service and urgent outpatient prescription drug claims and appeals. |

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

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

(1) **A claim must include the following elements to trigger the Plan's claim filing procedures:**

(A) Be **written or electronically** submitted (oral communication is acceptable only for urgent care claims);

(B) Be **received by the Appropriate Claims Administrator** (see the definition of Appropriate Claims Administrator in this Article);

(C) **Name** a specific individual;

(D) **Name** a specific medical condition or symptom;

(E) **Name a specific treatment, service or product** for which approval or payment is requested; and

(F) **Made** in accordance with the Plan's claim filing procedures described in this Article.

(2) **A claim is NOT:**

(A) A request made by **someone other than** the individual or his/her authorized representative;

(B) A request made by a person who will not identify himself/herself (anonymous);

(C) A **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;

(D) A request for prior approval of Plan benefits where prior approval is not required by the Plan;

(E) An **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal;

(F) A **submission of a prescription** with a subsequent Adverse Benefit Determination at the point of sale at a retail pharmacy or from a mail order service.

(d) **Concurrent Care Claim**: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

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

(f) **Disability Claim:** A disability claim is a claim for Weekly Disability benefits under the Plan to which the Plan conditions the availability of the benefit on proof of a claimant's disability.

(g) **Health Care Professional**: A Health Care Professional is a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

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

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

(j) **Pre-Service Claim**: A pre-service claim (a claim which requires precertification) is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The list of drugs that require precertification are available from the Prescription Benefit Manager (PBM) whose name and phone number are listed on the Quick Reference Chart in the front of this document.

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

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

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

(m) **Urgent Care Claim**: An urgent care claim is a claim for medical care or treatment in which applying the time periods for precertification:

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

**Section 9: Review Of A Matter That Is Not A Claim (as defined in this Article)**

A Plan Participant may request review of a matter that is not a claim (as defined in this Article) by writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document.

**Section 10: Authorized Representative**

This Plan recognizes an authorized representative as any person at least 18 years old whom you have so designated in writing as the person who can act on your behalf to file a claim under this Plan (because of your death, disability or other reason acceptable to the Board of Trustees or its designee) and to appeal an Adverse Benefit Determination. An authorized representative under this Plan includes a Network Health Care Professional.

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

completed authorized representative form available from the Appropriate Claims Administrator. If the individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has a notarized power of attorney for health care purposes, a Court order of guardianship/conservatorship, or is the individual's legal Spouse, parent, grandparent or child over the age of 18.

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

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

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

**Section 11: Requesting Documents in Accordance with Mental Health Parity and Addiction Equity Act (MHPAEA)**

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

**Section 12: How To File A Post-Service Claim For Benefits Under This Plan**

(a) A claim for post-service benefits is a request for Plan benefits (that is not a pre-service claim) made by you or your authorized representative, in accordance with the Plan's claim filing procedures, described in this Article. See also Section 8 of this Article for the definition of a "claim" and the information on what is and is not considered a claim.

(b) Plan benefits for post-service claims are considered for payment on the receipt of a **written** proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim, but sometimes additional information or records may be required.

(c) Generally, Plan benefits for a Hospital or Health Care Facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services.

(d) If health care services are provided through a Network Health Care Facility or Health Care Practitioner, that provider will usually submit the written proof of claim directly to the Appropriate Claims Administrator.

(e) If you pay for Out-of-Network health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to that Appropriate Claims Administrator that you or your covered Dependent paid some or all of those charges. Plan benefits will be paid to you up to the amount allowed by the Plan for those eligible expenses. Refer to the Quick Reference Chart in the front of this document for the address of each of the Appropriate Claims Administrators. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.

(f) **Claim Forms:** Occasionally a Health Care Facility or Health Care Practitioner will send a claim (bill) directly to you. In this case you should contact the Appropriate Claims Administration to inquire if they want a claim form submitted along with the bill. If so:

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

(2) You can attach the bill for professional services from your Physician or Health Care Facility or Health Care Practitioner if it contains **all** of the following information:

- A description of the services or supplies provided.
- Details of the charges for those services or supplies including CPT/CDT codes.

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

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

(4) If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

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

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

(h) The Appropriate Claims Administrator will review your post-service claim not later than **30 calendar days** from the date the Appropriate Claims Administrator receives the claim. You will be notified if you did not properly follow the post-service claims process.

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

(j) The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.

(k) If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

(l) If you provide the requested information within the 60-day period, a claim determination will be made not later than 15 calendar days from the date the Claim Administrator receives the additional information.

(m) If you have not provided the information requested in the Notice of Extension within the 60-day period, your claim will be reviewed without such information. If it is denied you may re-file it with all information and documentation that is required, within two years from the date on which you originally filed that claim.

(n) **Proof of Dependent Status:** When processing claims submitted on behalf of a Dependent the Plan may require proof of Dependent status in accordance with Article II on Eligibility.

(o) When processing **claims related to an accident** the Administrative Office may need information about the details of the accident.

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

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

(r) **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) in addition to the Explanation of Benefits or EOB form. This notice of initial denial will:

(1) Identify the claim involved (*e.g.*, date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);

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

(3) Give the specific reason(s) for the denial; including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

(4) Reference the specific Plan provision(s) on which the determination is based;

(5) Describe any additional information needed to complete the claim and an explanation of why such added information is necessary;

(6) Provide an explanation of the Plan's internal appeal procedure and external review processes (when applicable), along with time limits and information regarding how to initiate an appeal;

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

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

(9) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), contain a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(10) Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when applicable).

(s) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

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

**Section 13: Appeal Of A Denial Of A Post-Service Claim**

(a) For post-service Medical, Dental and Vision plan claim appeals, this Plan maintains a 2-level appeals process. The first level of claim appeal must be submitted in writing to the Appropriate Claims Administrator. If still not satisfied, the second level of claim appeal must be submitted in writing to the Administrative Office for review by the Board of Trustees. Contact information is listed on the Quick Reference Chart in this document.

You will be provided with:

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

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

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

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

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

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

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

(B) Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

(b) Under this Plan's 2-level appeal process, the first level of review on the post service appeal, performed by the Appropriate Claims Administrator will be made no later than **30 calendar days** from receipt of the appeal.

(1) There is **no extension permitted** to the Plan in the appeal review process.

(2) You will be sent a written (or electronic, as appropriate) notice of the appeal determination (containing information as discussed below in Subsection (f)).

(3) If still dissatisfied with the initial appeal level determination you will have 60 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Administrative Office for review by the Board of Trustees.

(c) The Board of Trustees will make a second level determination on the appeal as follows:

(1) If your request is submitted more than 30 days before the next Board meeting, the review will occur at the next Board meeting date.

(2) **If your request is submitted within 30 days of the next Board meeting**, the review will occur no later than the second Board meeting following the Board's receipt of the appeal.

(3) If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made not later than the third meeting of the Board following the Plans' receipt of the request for review.

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

(d) You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a

person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

(e) If the claim was denied due to a medical judgment (not Medically Necessary, Experimental or Investigational) the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

(f) You will receive a notice of the appeal determination no later than 5 calendar days after the benefit determination is made. If that determination is adverse, it will include:

(1) Information that is sufficient to identify the claim involved (*e.g.*, date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);

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

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

(4) Reference the specific Plan provision(s) on which the determination is based;

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

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

(7) An explanation of the Plan's second level appeal process and external review process (when applicable), along with any time limits and information regarding how to initiate any next level of review (when applicable), as well as a statement of the voluntary Plan appeal procedures, if any;

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

(9) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

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

(11) Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when applicable).

(g) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

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

**Section 14: How To File An Urgent Care Claim For Benefits Under This Plan**

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

(b) You or your authorized representative may request precertification of urgent care claims (as defined previously in this Article) orally or by writing to the Appropriate Claims Administrator (as defined in this Article and whose phone number and address are listed on the Quick Reference Chart in the front of this document).

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

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

(e) You will be notified of the Plan's benefit determination as soon as possible but **not later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim filing procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.

(f) **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but not later than 24 hours after receipt of the urgent care claim by the Appropriate Claims Administrator, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours, to provide the information. You will then be notified of the benefit determination on the urgent care claim as soon as possible but not later than 48 hours after the earlier of receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

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

(h) **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided not later than three calendar days after the oral notice. The notice of initial urgent care claim denial will:

(1) Identify the claim involved (*e.g.*, date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);

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

(3) Give the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;

(4) Reference the specific Plan provision(s) on which the determination is based;

(5) Describe any additional information needed to complete the claim and an explanation of why such added information is necessary;

(6) Provide an explanation of the Plan's internal appeal procedure and external review processes (when applicable), along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process and external review process for urgent care claims;

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

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

(9) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), contain a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and

(10) Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when applicable).

(i) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

(j) **If you disagree with a denial of an urgent care claim,** you or your authorized representative may file an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. Appeals filed after this 180-calendar day period will not be accepted.

**Section 15: Appeal Of A Denial Of An Urgent Care Claim**

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

(b) You will be provided with:

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

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

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

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

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

(6) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or not appropriate, the Plan will:

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

(B) Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

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

(d) The notice of appeal review of an urgent care claim will be provided orally with written (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(1) Information that is sufficient to identify the claim involved (*e.g.*, date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);

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

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

(4) Reference the specific Plan provision(s) on which the determination is based;

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

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

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

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

(9) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

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

(11) Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when applicable).

(e) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

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

**Section 16: How To File A Concurrent Claim For Benefits Under This Plan**

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

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

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

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

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

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

(f) **If the concurrent claim is approved** you will be notified orally before the benefit is reduced or treatment terminated, followed by written (or electronic, as applicable) notice.

(g) **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:

(1) Identify the claim involved (*e.g.*, date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);

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

(3) Give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

(4) Reference the specific Plan provision(s) on which the determination is based;

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

(6) Describe any additional information needed to complete the claim and an explanation of why such added information is necessary;

(7) Provide an explanation of the Plan's internal appeal procedure and external review processes (when applicable), along with time limits and information on how to initiate an appeal;

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

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

(10) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), contain a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(11) Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when applicable).

(h) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

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

**Section 17: Appeal Of A Denial Of A Concurrent Care Claim**

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

(b) You will be provided with:

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

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

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

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

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

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

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

(B) Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

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

(8) The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(A) Information sufficient to identify the claim involved (*e.g.*, date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);

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

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

(D) Reference the specific Plan provision(s) on which the determination is based;

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

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

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

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

(I) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

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

(K) Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when applicable).

(9) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

(10) This concludes the concurrent claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

**Section 18: How To File A Pre-Service Claim For Benefits Under This Plan**

(a) A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) to the Appropriate Claims Administrator whose phone number and address are listed on the Quick Reference Chart in the front of this document.

(b) The pre-service claim will be reviewed not later than **15 calendar days** from the date the pre-service claim is received by the Appropriate Claims Administrator. You will be notified if you did not properly follow the post-service claims process.

(c) The 15 calendar day review period may be **extended one time, for up to 15 additional calendar days**, if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control, the date by which they expect to make a decision and notify you prior to the expiration of the initial 15-day period using a written Notice of Extension.

(d) The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.

(e) If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

(f) If you provide the requested information within the 60-day period, a claim determination will be made not later than 15 calendar days from the date the Appropriate Claims Administrator receives the additional information.

(g) If you have not provided the information requested in the Notice of Extension within the 60-day period, your claim will be reviewed without such information. If it is denied you may re-file it with all information and documentation that is required, within two years from the date on which you originally filed that claim.

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

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

(j) **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:

(1) Identify the claim involved (*e.g.*, date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);

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

(3) Give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

(4) Reference the specific Plan provision(s) on which the determination is based;

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

(6) Describe any additional information needed to complete the claim and an explanation of why such added information is necessary;

(7) Provide an explanation of the Plan's internal appeal procedure and external review processes (when applicable), along with time limits and information regarding how to initiate an appeal;

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

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

(10) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(11) Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when applicable).

(k) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

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

**Section 19: Appeal Of A Denial Of A Pre-Service Claim**

(a) **Appeals must be in writing** to the Appropriate Claims Administrator (as defined in this chapter and whose address is listed on the Quick Reference Chart in the front of this document.) You will be provided with:

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

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

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

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

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

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

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

(B) Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

(7) There is **no extension permitted** to the Plan in the pre-service appeal review process.

(8) The Appropriate Claims Administrator will make a determination **not later than 30 calendar days** from receipt of the appeal.

(9) You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(A) Information sufficient to identify the claim involved (*e.g.*, date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);

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

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

(D) Reference the specific Plan provision(s) on which the determination is based;

(E) A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;

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

(G) An explanation of the Plan's external review processes (when applicable), along with any time limits and information regarding how to initiate any next level of review (when applicable), as well as a statement of the voluntary Plan appeal procedures, if any;

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

(I) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

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

(K) Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

(10) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

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

**Section 20: How To File A Claim For Weekly Disability Benefits Under The Accident And Sickness Benefit**

(a) A claim for Weekly Disability benefits (refer to Article III that addresses Weekly Disability Benefits) is a request for disability benefits made by you or your authorized representative (as defined in this Article) in accordance with these disability claim filing procedures. See also Section 8 of this Article for a definition of a "claim" and the information on what is and is not considered a claim.

(b) Eligible Active Employees who become Totally Disabled as a result of a non-occupational sickness or accidental bodily injury, while covered under this Plan, should apply (file a claim) for Weekly Disability benefits within 30 calendar days after the date on which the illness or injury began, according to the following steps:

(1) Obtain a disability claim form from the Administrative Office.

(2) Complete the patient portion of the form.

(3) Then give the form to your Physician to complete the Health Care Provider section of the form.

(4) Return the completed disability claim form to the Administrative Office at their address listed on the Quick Reference Chart in the front of this document.

(c) **Disability claims will be determined by the Plan not later than 45 calendar days after receipt of the claim for Weekly Disability benefits.**

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

(1) Proof of disability must be provided to the Plan no later than 90 calendar days after the end of the period for which Weekly Disability benefits are payable. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.

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

(e) The Board of Trustees determines if Employees are eligible to receive Weekly Disability benefits under this Plan.

(f) The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) not later than 45 calendar days from the date the Plan receives the claim.

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

(1) If, prior to the end of this first 30-day extension, the Plan determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided the Plan notifies you prior to the end of the first 30-day extension period of the circumstances requiring the second extension and the date the Plan expects to render a decision.

(2) A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues.

(3) If you provide the requested information within the 60-day period, a claim determination will be made not later than 15 calendar days from the date the Administrative Office receives the additional information.

(4) If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed.

(5) If you have not provided the information requested in the Notice of Extension within the 60-day period, your claim will be reviewed without such information. If it is denied you may re-file it with all information and documentation that is required, within two years from the date on which you originally filed that claim.

(h) Weekly Disability benefits begin when the claim for Weekly Disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim. If the claim for Weekly Disability benefits is approved, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

(i) **If the claim for Weekly Disability benefits is denied** in whole or in part, a notice of this initial denial (Adverse Benefit Determination) will be provided to the Employee in writing (or electronically, as applicable). This notice of initial denial will:

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

(2) Reference the specific Plan provision(s) on which the determination is based;

(3) Contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;

(4) Describe any additional information needed to complete the claim and an explanation of why such added information is necessary;

(5) Provide an explanation of the Plan's appeal procedure along with time limits;

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

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

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

(9) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), contain a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

(j) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

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

**Section 21: Appeal Of A Denial Of A Disability Claim**

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

(1) The opportunity, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits, upon request and without charge.

(2) The opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

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

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

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

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

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

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

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

(B) The Plan will provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

(b) The Board of Trustees will make a determination on the appeal as follows:

(1) If your request is submitted more than 30 days before the next Board meeting, the review will occur at the next Board meeting date.

(2) **If your request is submitted within 30 days of the next Board meeting**, the review will occur no later than the second Board meeting following the Board's receipt of the appeal.

(3) If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made not later than the third meeting of the Board following the Plans' receipt of the request for review.

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

(c) You will receive a notice of the Board's appeal determination no later than five calendar days after the benefit determination is made. If that determination is adverse, it will include:

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

(2) Reference the specific Plan provision(s) on which the determination is based;

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

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

(5) A description of any applicable contractual limitation periods on benefit disputes (such as the Plan's time limit on when a lawsuit may be filed following an appeal

(6) A statement of the voluntary Plan appeal procedures, if any;

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

(8) If the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

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

(d) If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

(e) This concludes the disability appeal process under this Plan. This Plan does not offer a voluntary appeal process.

**Section 22: Overview Charts.**

The following charts outline the timeframes for the claim filing and claim appeal procedures.

| Overview Of Claims And Appeals Timeframes | | | | | |
|---|---|---|---|---|---|
| | **Urgent** | **Concurrent** | **Pre-service** | **Post-service** | **Disability** |
| Plan must make **Initial Claim Benefit Determination** as soon as possible but not later than: | 72 hours | Before the benefit is reduced or treatment terminated. | 15 days | 30 days | 45 days |
| Extension permitted during initial benefit determination? | No[1] | No | Yes, one 15-day extension. | Yes, one 15-day extension. | Yes, up to 2 extensions each 30 days in duration. |
| Appeal Review must be submitted to the Plan within: | 180 days | 180 days | 180 days | 180 days | 180 days |
| Plan must make **Appeal Claim Benefit Determination** as soon as possible but not later than: | 72 hours | Before the benefit is reduced or treatment terminated. | 30 days | According to the timeframes noted in the chart below for making decisions at Board meetings. | According to the timeframes noted in the chart below for making decisions at Board meetings. |
| Extension permitted during appeal review? | No | No | No | No | Yes |

[1]: no formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

| Overview of Post-service and Disability Appeal Timeframes for Multiemployer Plans with Committee or Boards of Trustees that meet at least Quarterly | | |
|---|---|---|
| Appeal filed **within 30 days** of the next Board meeting: | Board review occurs no later than the second meeting following receipt of the appeal. | If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal. |
| Appeal filed **more than 30 days** before next Board meeting: | Board review occurs at the next Board meeting date. | If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal. |
| Board's decision on the appeal to be provided to claimant as soon as possible after the Board decision but not later than 5 days after the Board's decision date. | | |

**Section 23: External Review of Claims**

This External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this Section, references to "you" or "your" include you, your covered Dependent(s), and you and your covered Dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

You may seek further, external review by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim including a claim under the HRA Plan, is denied and it fits within the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment; and/or
- The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this **external review process does not pertain** to claims for Dental PPO Plan, Vision Plan, Life/Death benefits, AD&D benefits, or Weekly Disability.

Generally, under the Medical Plan, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

(a) **External Review of Standard (Non-Urgent) Claims.** Your request for external review of a standard (not urgent) claim must be made, in writing, within four months of the date that you receive notice of a Claim Appeal Benefit Determination. For convenience, this Determination is referred to below as an "Adverse Determination."

An external review request on a standard claim should be made to the following applicable **Plan designee**:

- The Medical Plan Claims Administrator, with respect to a denied claim not involving retail or mail order prescription drug expenses or utilization management services;
- The Prescription Benefit Manager (PBM), with respect to a denied claim involving retail or mail order prescription drug expenses;
- The Utilization Management Program provider, with respect to a denied Pre-service or concurrent review determination not involving prescription drug expenses or behavioral health expenses;

Contact information for the Medical Plan Claims Administrator, the Prescription Benefit Manager (PBM), and the Utilization Management Program provider is identified in the Quick Reference Chart, as amended from time to time.

(1) **Preliminary Review of Standard Claims.**

(A) Within five business days of the Plan's or appropriate Plan designee's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:

(i) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(ii) The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;

(iii) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

(iv) You have provided all of the information and forms required to process an external review.

(B) Within one business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

(i) If your request is complete and eligible for external review; or

(ii) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

(iii) If your request is not complete, the notice will describe the information or materials needed to complete the request, and allow you to complete the request for external review within the four-month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

(2) **Review of Standard Claims by an Independent Review Organization (IRO).**

(A) If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

(i) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within 10 business days).

(ii) Within five business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

(iii) If you submit additional information related to your claim to the IRO, the assigned IRO must, within one business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. **Reconsideration** by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(iv) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim as if it is new, and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) Health Care Providers, other information from you or the Plan, reports from appropriate Health Care Professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(B) The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee **within 45 days** after the IRO receives the request for the external review.

(i) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(ii) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

(C) The assigned IRO's decision notice will contain:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service,

Health Care Facility or Health Care Practitioner, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

(ii) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

(iv) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

(v) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

(vi) A statement that judicial review may be available to you; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

(b) **External Review of Expedited Urgent Care Claims.**

(1) You may request an expedited external review if:

(A) You receive an adverse Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

(B) You receive an adverse Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Your request for an expedited external review of a non-standard claim should be made to the following applicable **Plan designee**:

- The Utilization Management Program provider, with respect to a denied Urgent, Pre-service or Concurrent review determination not involving retail or mail order prescription drug expenses or behavioral health expenses;
- The Prescription Benefit Manager (PBM), with respect to a denied claim involving retail or mail order prescription drug expenses.

Contact information for the Utilization Management Program provider, and the Prescription Benefit Manager (PBM), is identified in the Quick Reference Chart, as amended from time to time.

(2) **Preliminary Review for an Expedited Claim.**

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (*e.g.*, telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

(3) **Review of Expedited Claim by an Independent Review Organization (IRO).**

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (*e.g.*, meaning via telephone, fax,

courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim as if it is new, and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **72 hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

(A) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(B) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

(c) **Overview of the Timeframes During the Federal External Review Process.**

| **Steps in the External Review Process** | **Timeframe for Standard Claims** | **Timeframe for Expedited Urgent Care Claims** |
|---|---|---|
| Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*) | Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice) | After receipt of an Adverse Claim Benefit Determination (benefits denial notice) |
| Plan or appropriate Plan designee performs preliminary review | Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request | Immediately |
| • Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review | Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review | Immediately |
| • When appropriate, claimant's timeframe for completing an incomplete external review request | Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete | Expeditiously |
| **Plan or appropriate Plan designee assigns case to IRO** | **In a timely manner** | **Expeditiously** |

| Steps in the External Review Process | Timeframe for Standard Claims | Timeframe for Expedited Urgent Care Claims |
|---|---|---|
| Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information | In a timely manner | Expeditiously |
| Time period for the Plan or appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination | Within 5 business days of assigning the IRO to the case | Expeditiously |
| Claimant's submission of additional information to the IRO | Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days) | Expeditiously |
| IRO forwards to the Plan any additional information submitted by the claimant | Within 1 business day of the IRO's receipt of the information | Expeditiously |
| If (on account of the new information) the Plan reverses it's denial and provides coverage, a Notice is provided to claimant and IRO | Within 1 business day of the Plan's decision | Expeditiously |
| External Review decision by IRO to claimant and Plan | Within 45 calendar days of the IRO's receipt of the request for external review | As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.) |
| Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination | Plan must immediately provide coverage or payment for the claim | Plan must immediately provide coverage or payment for the claim |

**Section 24: Limitation On When A Lawsuit May Be Started**

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. No lawsuit may be started more than three years after the end of the year in which health care services were provided or, if the claim is for Weekly Disability benefits, more than three years after the start of the disability.

**Section 25: Discretionary Authority Of Board Of Trustees And Designees**

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

that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

**Section 26: Facility Of Payment**

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, Claims Administrator nor any other designee of the Board of Trustees will be required to see to the application of the money so paid.

**Section 27: Elimination Of Conflict Of Interest**

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those person's employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

# ARTICLE VIII: COORDINATION OF BENEFITS (COB)

**Section 1: Benefits Subject to this Provision**

All self-funded Dental PPO Plan and Vision Plan benefits provided under these Rules and Regulations are subject to the following additional provisions and limitations. Death benefits, Accidental Death and Dismemberment benefits, and Weekly Disability benefits are not provided under these Rules and Regulations. Coordination of Benefits for the Medical Plan is discussed in Article XV.

**Section 2: Definitions**

(a) **Plan:** The term **"Plan"** means, for purposes of this Article only, any plan providing benefit or services for or by reasons of medical, dental or vision care or treatment, which benefits or services are provided by (1) group, blanket or franchise insurance coverage, (2) service plan contracts, group practice, individual practice and other prepayment coverage, (3) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (4) any coverage under governmental programs, and any coverage required or provided by any statute.

The term "**Plan"** shall be construed separately with respect to each benefit or service which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(b) The term **"This Plan"** means, for purposes of this Article only, the Rules and Regulations that provide the self-funded Dental PPO Plan, and Vision benefits. Coordination of Benefits for the Medical Plan is discussed in Article XV.

(c) The term **"Allowable Expense"** means the Allowed Charge for any necessary, reasonable, and customary item of medical, dental and vision care expenses incurred, a portion of which is covered under one of the Plans covering the Eligible Individual for whom claim is made.

When the Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The Fund shall not be required to determine the existence of any other Plan, or the amount of benefits payable under any Plan other than This Plan. The payment of benefits under This Plan shall be affected by the benefits payable under other Plans only if the Fund is furnished with information concerning the existence of such other Plans by the Eligible Individual or insurance company, organization, agency of government or person.

(d) **Claim Determination Period:** The term "Claim Determination Period" means a period commencing with any January 1 and ending at 12 o'clock midnight on the next succeeding December 31st or that portion of such period during which the Eligible Individual with respect to whose expense claim is based has been covered under This Plan.

**Section 3: Effect on Benefits**

(a) This provision shall apply in determining the benefits due an Eligible Individual under This Plan for any Claim Determination Period if, for the Allowable Expense incurred as to such Eligible Individual during such period, the sum of the benefits that would be payable under This Plan in the absence of this provision, and the benefits that would be payable under all other Plans in the absence in them of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(b) As to any Claim Determination Period in which this provision is applicable, the benefits that would be payable under This Plan in the absence of this provision for the Allowable Expenses incurred as to such Eligible Individual during such Claim Determination Period shall be reduced to the extent necessary so that the sum of (1) such reduced benefits and (2) all the benefits payable for such Allowable Expenses under all other Plans, except as provided in Subsection (c) of this Section 3, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made for them.

(c) If another Plan covering the Eligible Individual covered by This Plan contains a similar non-duplication of benefits provision which coordinates its benefits with those of This Plan and would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and the rules set forth in Subsection (d) of this Section 3 would require This Plan to determine its benefits before such other Plan, then the benefits of such other Plan will not be considered for the purposes of determining the benefits due under This Plan.

(d) For the purpose of Subsection (c) of this Section 3, the **rules establishing the order of benefit determination** are:

(1) The benefits of a Plan which covers the person on whose expense claim is based other than as a Dependent shall be determined before the benefits of a Plan which covers such person as a Dependent;

(2) The benefits of a Plan which covers a child as a Dependent of the parent whose birthday (excluding year of birth) occurs earlier in the Calendar Year pays first. If both parents have the same birthday (month and date), the Plan which has insured the Dependent, for whom claim is being made, for the longer period of time pays first. However, if the parents are divorced or are separated, the Plan covering the parent who has custody will pay first. If the parent with custody remarries, the "order of payment" is as follows:

(A) Natural parent with whom the child resides;

(B) Step-parent with whom the child resides; and

(C) Natural parent not having custody of the child.

This order of payment can change if the divorce decree directs one of the parents to be financially responsible for the Medical, Dental, Vision, or other health care expenses of the child.

**NOTE:** If the other Plan does not determine Dependents' benefits based on the parents' date of birth, then that Plan's order of benefits determination will apply.

(3) When rules (1) and (2) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expense claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

(e) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under This Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of This Plan.

(f) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in Rule 3 above (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parents coverage and the dependent's self or spouse coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 3 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the dependent.

(g) This Plan does not coordinate benefits with an individual plan. This means that when a Plan Participant is covered by this Plan and also covered by an individual (non-group) plan/policy including a policy through the Health Insurance Marketplace, this Plan will not pay benefits toward claims that are covered by that individual plan/policy.

(h) **Special Dual Coverage Provision**: The Medical, Dental and Vision Plans utilize a coordination of benefits provision that allows a Plan participant to be covered under this Plan as both an employee and as a dependent. This means that if both the husband and wife are benefits-eligible employees covered under the Fund and one spouse covers the other spouse as a Dependent on their coverage, or the parent and a child are both benefits-eligible employees under the Fund and the parent covers the child as a dependent on their coverage, then the Plan will process eligible claims at 100% for the Medical PPO plan for the double covered participants.

**Section 4: Medicare and Other Government Programs**

(a) **Medicare**: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. If you, your covered Spouse or Dependent Child becomes covered by Medicare, because of disability, and you retain your coverage under This Plan, as long as you remain actively employed, your health care coverage will continue to provide the same Benefits, and This Plan pays first and Medicare pays second.

Any Early Retiree and/or Dependent who becomes entitled to Social Security Disability Income benefits and becomes entitled to Medicare coverage, note that the Arizona Pipe Trades Health and Welfare Trust Fund will no longer be your primary insurance (whether you have enrolled in Medicare or not). You need to enroll in

Medicare Parts A and B and/or C to get the maximum amount of benefits from This Plan. (Refer to the Fund's separate Medicare eligible Retiree SPD/Plan Rules and Regulations document.)

(b) **End-Stage Renal Disease (ESRD):** If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), This Plan pays first and Medicare pays second for **30 months** starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and This Plan pays second.

(c) **When Covered by This Plan and also by a Medicare Part D Prescription Drug Plan:** If you have dual coverage under both This Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage:

- For Medicare eligible Active Employees and non-Medicare eligible Retirees and their Medicare eligible Dependents, This Plan pays primary and Medicare Part D coverage is secondary.
- For Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage is primary and This Plan pays secondary. Note that dual coverage may affect your Annual Out-of-Pocket Limit under your Medicare Part D prescription drug plan.

For more information on Medicare Part D refer to www.medicare.gov or contact the Administrative Office.

(d) **Summary Chart on Coordination of Benefits (COB) with Medicare:** If you are covered by Medicare and also have other group health plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

| **Summary of the Coordination of Benefits between Medicare and the Group Health Plan** | | | |
|---|---|---|---|
| **If you:** | **Situation** | **Pays First** | **Pays Second** |
| Are covered by both Medicare and Medicaid | Entitled to Medicare and Medicaid | Medicare | Medicaid, but only after other coverage such as a group health plan has paid |
| Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working Spouse of any age | The employer has less than 20 employees* | Medicare | Group health plan |
| | The employer has 20 or more employees | Group health plan | Medicare |
| Have an employer group health plan after you retire and are age 65 or older | Entitled to Medicare | Medicare | Group health plan (*e.g.*, a retiree plan coverage) |
| Are disabled and covered by a large group health plan from your work or from a family member who is working | The employer has less than 100 employees** | Medicare | Group health plan |
| | You are entitled to Medicare or the Employer has 100 or more employees | Group health plan | Medicare |
| Have End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan) | First 30 months of eligibility or entitlement to Medicare | Group health plan | Medicare |
| | After 30 months of eligibility or entitlement to Medicare | Medicare | Group health plan |
| Are covered under worker's compensation because of a job-related injury or illness | Entitled to Medicare | Workers' compensation for worker's compensation-related claims | Usually does not apply, however, Medicare may make a conditional payment. |

| Summary of the Coordination of Benefits between Medicare and the Group Health Plan | | | |
|---|---|---|---|
| **If you:** | **Situation** | **Pays First** | **Pays Second** |
| Have black lung disease and are covered under the Federal Black Lung Benefits Program | Entitled to Medicare and the Federal Black Lung Benefits Program | Federal Black Lung Benefits Program for black lung-related claims | Medicare |
| Have been in an accident where no-fault or liability insurance is involved | Entitled to Medicare | No-fault or Liability insurance, for the accident-related claims | Medicare |
| Are a veteran and have Veterans' benefits | Entitled to Medicare and Veterans' benefits | Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service. | Usually does not apply |
| Are covered under TRICARE | Entitled to Medicare and TRICARE | Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider. | TRICARE may pay second |
| Are age 65 or over OR, are disabled and covered by both Medicare and COBRA | Entitled to Medicare | Medicare | COBRA |
| Have End-Stage Renal Disease (ESRD) and COBRA | First 30 months of eligibility or entitlement to Medicare | COBRA | Medicare |
| | After 30 months | Medicare | COBRA |
| *or if it is part of a multiemployer plan where one employer has 20 or more employees, if the Plan has requested an exception that is approved by Medicare.<br>** and isn't part of a multiemployer plan where any employer has 100 or more employees.<br>See also: https://es.medicare.gov/publications/02179-how-medicare-works-with-other-insurance.pdf or 1-800-Medicare for more information | | | |

(e) **When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare Beneficiary (meaning an individual who is determined by the Social Security Administration to be eligible for and has actually enrolled in Medicare benefits) is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare Beneficiary enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare Beneficiary receives pursuant to it.

**Section 5: Coordination With Government And Other Programs**

(a) **Medicaid**: If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

(b) **TRICARE**: If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active members of the armed services only. If an Eligible Individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

(c) **Veterans Affairs/Military Medical Facility Services**: If an Eligible Individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an Eligible Individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.

(d) **Motor Vehicle Coverage Required by Law**: If an Eligible Individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

(e) **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

(f) **Other Coverage Provided by State or Federal Law**: If an Eligible Individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

**Section 6: Workers' Compensation**

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. Before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Plan Administrator, (the Board of Trustees), or the Claims Administrator(s) of their rights to recover any payments that the Plan has advanced.

**Section 7: Right to Receive and Release Necessary Information**

For the purpose of determining the applicability of and implementing the terms of this provision of This Plan or any provision of similar purpose of any other Plan the Fund may, with the consent of the Eligible Individual, release to or obtain from an insurance company or other organization or person any information, with respect to any person, which the Fund deems to be necessary for such purposes. Any Eligible Individual claiming benefits under This Plan shall furnish to the Fund such information as may be necessary to implement this provision.

**Section 8: Right to Recovery**

Whenever payments have been made by the Fund with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Fund shall determine: (1) any persons to or for or with respect to whom such payments were made, or (2) insurance companies, service plans or any other organizations.

# ARTICLE IX: GENERAL PROVISIONS

**Section 1:**

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, any Eligible Employee may direct that benefits due the individual be paid to an institution in which the individual or his/her eligible Dependent is Hospitalized or to any provider of medical or dental services or supplies in consideration for medical, dental or Hospital services rendered or to be rendered.

**Section 2:**

In the event the Fund determines that the Eligible Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Employee has not provided the Fund with an address at which the individual can be located for payment, the Fund may, during the lifetime of the Eligible Employee, pay any amount otherwise payable to the Eligible Employee, to the Spouse, or to a relative by blood of the Eligible Employee or to any other person or institution determined by the Fund to be equitably entitled thereto. In the event of the death of the Eligible Employee before all amounts payable under Article III, Article IV, Article V, and Article VI have been paid, the Fund may pay any such amount to any person or institution determined by the Fund to be equitably entitled thereto. The remainder of such amount shall be paid to one or more of the following surviving relatives of the Eligible Employee: lawful Spouse, child or children, mother, father, brothers or sisters, or to the Eligible Employee's estate, as the Board of Trustees at its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Fund hereunder to the extent of such payment.

**Section 3:**

(a) No Eligible Employee, eligible Dependent, Beneficiary or other person shall have the right or claim to benefits under the Plan or any right or claim to payments from the Fund other than as specified in these Rules and Regulations, the rules of the Fund and the provisions of the Trust Agreement. Any dispute as to eligibility, type, amount of duration of such benefits or any right or claim to payments from the Fund shall be resolved by the Board of Trustees, or its Agent, under and pursuant to the Fund and the Plan and its decision of the dispute, right or claim shall be final and binding upon all parties thereto, subject only to such judicial review as may be in harmony with federal labor policy. The term "Agent" as used herein means any insurance company, insurance service or similar organization selected by the Board of Trustees to pay the benefits provided by the Fund or the Plan.

(b) See Article VII on Claim Filing and Appeals Procedures.

**Section 4:**

The provisions of these Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of these Rules and Regulations and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

**Section 5: General Statement Of Nondiscrimination: (Discrimination Is Against The Law)**

Effective January 1, 2017, the Arizona Pipe Trades Health and Welfare Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Arizona Pipe Trades Health and Welfare Trust Fund:

(a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

(b) Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Fund's Civil Rights Coordinator (contact information listed below).

If you believe that the Arizona Pipe Trades Health and Welfare Trust Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Fund's Civil Rights Coordinator:

BeneSys, Inc.
3109 N. 24th Street, Suite 105
Phoenix, AZ 85016
Phone: 602-956-1950 or Toll Free Phone: 1-877-429-7473

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Fund's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Free Language Assistance:** The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of Arizona:

| **ATTENTION: FREE LANGUAGE ASSISTANCE**<br>This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency. | |
|---|---|
| **Language** | **Message About Language Assistance** |
| Spanish | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-429-7473. |
| Navajo | D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-877-429-7473. |
| Vietnamese | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-429-7473. |
| Chinese | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-429-7473. |
| Arabic | مقر) 877-429-7473-1 مقرب لصتا .ناجملاب كل رفاوتت ةيوغلا ةدعاسملا تامدخ نإف ،ةغلا ركذا ثدحتت تنك اذإ (877-429-7473-1 مكبلاو مصلا فتاه: ةظوحلم:). |
| Tagalog | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-429-7473. |
| Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-429-7473 번으로 전화해 주십시오. |
| Serbo-Croatian | OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-429-7473. |
| French | ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-429-7473. |
| German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-429-7473. |
| Japanese | **注意事項**：日本語を話される場合、無料の言語支援をご利用いただけます。 1-877-429-7473 まで、お電話にてご連絡ください。 |
| Persian | **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-429-7473 تماس بگیرید. |
| Italian | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-429-7473. |
| Romanian | ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-429-7473. |
| Polish | UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-429-7473. |

# ARTICLE X: AMENDMENT AND TERMINATION

**Section 1:**

The Board of Trustees reserves the right to amend or terminate this Plan at any time. The process for Plan amendment/termination is as follows:

(a) The Board of Trustees has the responsibility for the formal initiation of all amendments.

(b) A designee of the Board of Trustees will review all proposed amendments and present a final amendment to the Board of Trustees.

(c) Final amendment approval is given by the Board of Trustees through majority voting.

# ARTICLE XI: SUBROGATION AND REIMBURSEMENT

**Section 1: Subrogation and Reimbursement Provisions.**

(a) **Advance on Account of Plan Benefits**

The Plan does not cover expenses for services or supplies for which a third-party pays due to any recovery, whether by settlement, judgment or otherwise, but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), **subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or Dependent(s) if and when there is any recovery from any third-party. The right of reimbursement will apply:**

(1) Even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and

(2) Even if the recovery is not sufficient to make the ill or injured Employee and/or Dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and

(3) Without any reduction for legal or other expenses incurred by the Employee and/or Dependent(s) in connection with the recovery against the third-party or that third-party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and

(4) Regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule).

(5) Even if the recovery was reduced due to the negligence of the covered Employee or covered Dependent (sometimes referred to as "contributory negligence"), or any other common law defense.

(b) **Reimbursement and/or Subrogation Agreement**

The covered Employee **and/or** any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor Dependent Child) or Spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights**.

(c) **Cooperation with the Plan by All covered individuals**

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

(1) To reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third-party's insurer for the entire amount Advanced;

(2) That the Plan has the first right of reimbursement from any judgment or settlement;

(3) To do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights;

(4) To not assign the right of recovery to any third-party without the specific consent of the Plan;

(5) To notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third-party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third-party or third-party's insurer based on those acts; and

(6) To inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third-party.

(d) **Subrogation**

(1) By accepting an Advance, the covered Employee and/or covered Dependent's jointly agree that the Plan will be subrogated to the covered Employee and/or covered Dependent's right of recovery from a third-

party or that third-party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third-party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.

(2) Under its subrogation rights, the Plan may, at its discretion:

- Start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or
- Intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third-party or third-party's insurer concerning the injury or illness that resulted in the Advance.

(e) **Lien and Segregation of Recovery**

By accepting the Advance, the covered Employee and/or covered Dependent agrees to the following:

(1) The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment, or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third-party, the third-party's insurer, and the third-party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

(2) The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.

(3) Should the covered Employee, covered Dependent, or those acting on their behalf, fail to maintain this segregated account, or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

(f) **Remedies Available to the Plan**

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

(1) Apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or

(2) Obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s).

# ARTICLE XII: DISCLAIMER

**Section 1:**

Weekly Disability, Medical Plan, Dental PPO Plan and Vision benefits described in this document are not insured by any contract of insurance and there is no liability upon the Board of Trustees or any individual or entity to provide payment over and beyond the amount in the funds collected and available for such purpose. The Life and Accidental Death and Dismemberment benefits are insured.

# ARTICLE XIII: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Section 1: Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Arizona Pipe Trades Plan (including Medical Plan, Dental PPO Plan, and Vision benefits, Provider Networks, Claims Administration and Prescription Benefit Manager) (hereafter referred to in this Section as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you and is also available from the Administrative Office and on the Plan's website, www.azpipe.org. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and its Board of Trustees, will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Board of Trustees for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

**Section 2: The Plan's Use and Disclosure of PHI.**

The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your Health Care Providers (facility or practitioners). The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

(a) Determination of eligibility, coverage, cost sharing amounts (*e.g.*, cost of a benefit, Plan maximums, and Copayments as determined for an individual's claim), and establishing Employee contributions for coverage;

(b) Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;

(c) Medical Necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

(a) Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, Case Management and care coordination, disease management, contacting of Health Care Providers and patients with information about treatment alternatives and related functions,

(c) Underwriting, (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,

(d) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,

(e) Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

(f) Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

**Section 3: When an Authorization Form is Needed.**

Generally, the Plan will require that you sign a valid authorization form (available from the Plan's Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

**Section 4: Disclosure of PHI to the Board of Trustees.**

The Plan will disclose PHI to the Board of Trustees only in accordance with the following provisions. With respect to PHI, the Plan and its Board of Trustees agree to:

(a) Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

(b) Ensure that any agents, including their subcontractors, to whom the Plan provides PHI agree to the same restrictions and conditions that apply to the Plan with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

(c) Not use or disclose the information for employment-related actions and decisions;

(d) Not use or disclose the information in connection with any other benefit or employee benefit Plan (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

(e) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to the individual in accordance with the access requirements of HIPAA;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of PHI disclosures;

(i) Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA; and

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

If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

**Section 5: Use and disclosure of PHI.**

In order to ensure that PHI is maintained in accordance with HIPAA only the following Employees or classes of Employees may be given access to use and disclose PHI:

(a) The Plan's Privacy Officer;

(b) As designated by the Plan Administrator, the benefits personnel of the Administrative Office involved in the Plan administration of the Plan;

(c) Business Associates under contract to the Plan including but not limited to the Medical Plan and Dental PPO Plan Claims Administrator, Preferred Provider Organization (PPO) network, the retail and mail order prescription benefit plan administrator, the Utilization Management Company, the Plan's attorneys, accountants and consultants/actuaries; and

(d) The Board of Trustees, to the extent PHI must be reviewed in connection with a claim appeal or for such other purposes as may be required by law or the Plan documents.

The persons described in this Section may only have access to and use and disclose PHI for Plan administration functions. If these persons do not comply with this obligation, the Board of Trustees has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.

**Section 6: HIPAA Security.**

Effective April 21, 2005, in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

(b) Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

(c) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

(d) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

# ARTICLE XIV: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following information concerning the Plan is being provided in accordance with government regulations:

**Section 1:**

The name and type of administration of the Plan:

The Arizona Pipe Trades Health and Welfare Trust Fund is liable for all Medical Plan, Dental PPO Plan, Vision and Weekly Disability benefits under this group health plan. These benefits are administered by an independent Claims Administrator whose name and address are listed on the Quick Reference Chart in the front of this document.

The Plan is administered by a joint Board of Trustees, consisting of four Union representatives and four Employer representatives. Life and Accidental Death and Dismemberment benefits are insured by an Insurance Company whose name and address are listed on the Quick Reference Chart in the front of this document.

**Section 2:**

The name and address of the Plan Administrator/Plan Sponsor is:

Board of Trustees
Arizona Pipe Trades Health and Welfare Trust Fund
3109 N. 24th Street, Suite 105
Phoenix, AZ 85016
Phone: 602-956-1950 or Toll Free Phone: 1-877-429-7473

**Section 3:**

The names and business addresses of Board of Trustees are:

| **Union Trustees** | **Employer Trustees** |
|---|---|
| Aaron Butler<br>United Association Local 469<br>3109 N. 24th Street<br>Phoenix, AZ 85016 | Matt DeWitt<br>WD Manor Co.<br>1838 N. 23rd Avenue<br>Phoenix, AZ 85009 |
| Tony Gauthier (Chairperson)<br>United Association Local 469<br>3109 N. 24th Street<br>Phoenix, AZ 85016 | Darrell Fox<br>Trident Mechanical Services<br>2155 E. Jones Avenue<br>Phoenix, AZ 85040 |
| Larry Savage<br>United Association Local 469<br>3109 N. 24th Street<br>Phoenix, AZ 85016 | Nick Ganem (Secretary)<br>Bel-Aire Mechanical, Inc.<br>4201 N. 47th Avenue<br>Phoenix, AZ 85009 |
| Mark Aguire<br>United Association Local 469<br>3109 N. 24th Street<br>Phoenix, AZ 85016 | Carl Winter<br>Southland Industries<br>246 E. Watkins Street<br>Phoenix, AZ 85385 |

**Section 4:**

In addition to the Board of Trustees, the following persons have been designated as agents for the **service of legal process**:

| | |
|---|---|
| Gerald Barrett, Esq.<br>Gilbert & Sackman, ALC<br>3838 N. Central Avenue, Suite 900<br>Phoenix, AZ 85012 | Kerry Hodges, Esq.<br>Spencer Fane LLP<br>2415 E. Camelback Road, Suite 600<br>Phoenix, AZ 85016-4251 |

**Section 5:**

The **Employer Identification Number** assigned by Internal Revenue Service to the Board of Trustees is 86-0104344. The **Plan Number** assigned by the Board of Trustees is 501.

**Section 6:**

For purposes of maintaining the Fund's **fiscal records**, the year-end date is May 31.

**Section 7: Funding Medium**:

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses.

**Section 8: Contribution Source:**

All contributions to the Plan are made by Employers in accordance with Collective Bargaining Agreements with Local Union No. 469 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada. The Collective Bargaining Agreements require contributions to the Plan at a fixed rate per hour per month.

The Administrative Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreement. See Section 14 titled "Plan Documents and Reports" later in this Article if you wish to obtain additional information about the Collective Bargaining Agreements.

**Section 9: Organizations Accumulating Fund Assets:**

The Fund's assets and reserves are held in custody and invested by Verus. See Section 14 titled "Plan Documents and Reports" in this Article if you wish to obtain additional information concerning the Fund's investment of assets and checking accounts.

**Section 10: Plan Information:**

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described under Article II on Eligibility in this Plan's Rules and Regulations.

**Section 11: Plan Regulations:**

All of the types of benefits provided by the Plan and the complete terms of the benefits are set forth under the Articles of this Plan's Rules and Regulations.

**Section 12: Statement of ERISA Rights:**

As a Participant in the Arizona Pipe Trades Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About The Plan and Benefits:**

(a) Examine, without charge, at the Plan Administrator's office whose address is listed on the Quick Reference Chart in the front of this document, and at 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 US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

(b) 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.

(c) 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**

(a) 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, as described in the "Self-Payment Provisions and COBRA Information" Section

of the Summary Plan Description. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

(b) Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months after your Enrollment Date in your coverage.

**Prudent Actions by Plan Fiduciaries**

(a) In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries.

(b) 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**

(a) If your claim for a welfare benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

(b) 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.

(c) If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

(d) In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.

(e) 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**

(a) If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), US Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.

(b) You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

**Section 13: Claim Filing and Appeals:**

To file a claim or to appeal a denied claim, refer to Article VII on Claim Filing and Appeals Procedures of this Plan or Article XV for Medical Plan claim filing and appeals information . The name and address of the Administrative Office to whom claims and appeals are to be directed is listed on the Quick Reference Chart in the front of this document.

**Section 14: Plan Documents and Reports:**

You may examine the following documents at the Administrative Office during regular business hours, Monday through Friday, except holidays:

(a) Trust Agreement

(b) Collective Bargaining Agreements

(c) Plan Documents and all amendments

(d) Form 5500 or full Annual Report filed with the Internal Revenue Service and Department of Labor

(e) List of Contributing Employers

You may also obtain copies of the documents by writing for them and paying the reasonable cost of duplication. You should find out what the charge will be before requesting copies. If you prefer, you can arrange to examine these reports, during business hours, at your Union Office. To make such arrangements, call or write the Administrative Office. A summary of the Annual Report which gives details of the financial information about the Fund's operation is furnished free of charge to all Participants.

**Section 15: Spanish Language Assistance:**

Pongase en contacto con la oficina de administracion si no entiende los Beneficios del Plan al numero 1-877-429-7473.

This document contains a summary in English of your rights and benefits under the Plan. If you have difficulty understanding any part of this document, contact the Administrative Office at their phone number or address listed on the Quick Reference Chart in the front of this document.

**Section 16: Women's Health and Cancer Rights (WHCRA)**

This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

**Section 17: Newborns' and Mothers' Health Protection Act**

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (*e.g.*, Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans 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, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner 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 precertification. For information on precertification for a length of stay longer than 48 hours for vaginal delivery or 96 hours for C-section delivery, contact the Medical Plan Claims Administrator to precertify the extended stay.

**Section 18: Information About Medicare Part D Prescription Drug Plans For Individuals With Medicare**

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

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

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If, however, you keep this Plan coverage and also enroll in a Medicare Part D Prescription Drug Plan (PDP) you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. If you enroll in a Medicare Part D Prescription Drug Plan (PDP) you will need to pay the Medicare Part D premium out of your own pocket.

Medicare-Eligible Individuals can enroll in a Medicare Part D Prescription Drug Plan at one of the following three times:

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

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

**Section 19: Nondiscrimination In Health Care**

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

Nothing in this document is meant to interpret or extend or change in any way the provisions expressed in the rules and regulations of the health and welfare plan.

The Board of Trustees reserve the right to amend, modify or discontinue all or part of this Plan, whenever, in their judgment, conditions so warrant.

# ARTICLE XV: MEDICAL PLAN BENEFITS

The Medical Plan is self-funded and administered by CIGNA. The attached pages are referred to as a "certificate" and are provided to you by CIGNA, the Medical Plan Claims Administrator.

The Certificate contains a table of contents, for easy reference, that provides information about:

- What is covered under the Medical Plan including a Schedule of Medical Plan benefits;
- Outpatient Prescription Drug coverage;
- What is excluded (not covered) under the Medical Plan;
- How to file a claim for benefits under the Medical Plan;
- Coordination of Benefits (COB) when you are covered by this Medical Plan and another health coverage program;
- Expenses for which a Third Party may be responsible to pay;
- Required federal notices; and
- Definitions pertinent to the Medical Plan.

In addition to the benefits outlined in the following Article, the Plan offers an **Employee Assistance Program or EAP**. The EAP Program provides professional, confidential information, support, short-term counseling and referral (at no cost) to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage, family, work-related problems, substance abuse (alcohol and drug treatment), crisis intervention along with financial and legal problems.

**IMPROVEMENTS TO BENEFITS FOR CERTAIN SERVICES FROM OUT-OF-NETWORK PROVIDERS**

**Effective June 1, 2022**

The No Surprises Act was signed into law in December 2020. This Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from an Out-of-Network provider at an In-Network facility. Effective June 1, 2022, beneficiaries receiving these services will only be responsible for paying their In-Network cost sharing, and cannot be balance billed by the provider or facility for emergency services.

Effective June 1, 2022, the Plan is implementing a number of improvements to comply with the No Surprises Act.

**Emergency Services**

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is an In-Network provider or an In-Network emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network providers and In-Network emergency facilities;
- Without imposing cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network provider or an In-Network emergency facility;
- By calculating the cost-sharing requirement for Out-of-Network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any In-Network deductible or In-Network out-of-pocket maximums applied under the plan (and the In-Network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the

cost-sharing payments were made with respect to Emergency Services furnished by an In-Network provider or an In-Network emergency facility.

Your cost sharing amount for Emergency Services from Out-of-Network Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA).

**Non-Emergency Items or Services from an Out-of-Network Provider at an In-Network Facility**

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by an Out-of-Network at an In-Network facility, the items or services are covered by the Plan:

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

Your cost sharing amount for Non-emergency Services at In-Network Facilities by Out-of-Network Providers will be based on the lessor of billed charges from the provider or the QPA.

**Air Ambulance Services**

If you receive Air Ambulance services that are otherwise covered by the Plan from an Out-of-Network provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from an Out-of-Network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network provider.

**Payments to Out-of-Network Providers and Facilities**

The Plan will make an initial payment or notice of denial of payment for Emergency Services. Non-Emergency Services at In-Network Facilities by Out-of-Network Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Out-of-Network provider. The 30 day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the Out-of-Network provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

**External Review**

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by an Out-of-Network provider at an In-Network facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review.

**Continuity of Coverage**

If you are a Continuing Care Patient, and the contract with your In-Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

- You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the provider or facility; and
- You will be allowed up to 90 days of continued coverage at In-Network cost sharing to allow for a transition of care to an In-Network provider.

**Incorrect In-Network Provider Information**

A list of In-Network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

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

**Complaint Process**

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact Cigna or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

**Repeal of Emergency Department Payment Rules**

The Plan provision concerning payment for Emergency Room services, as required by the Affordable Care Act, is repealed for services provided on or after June 1, 2022, and replaced with the No Surprises Act requirements.

**NEW/REVISED DEFINITIONS OF THE PLAN**
**Effective June 1, 2022**

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

**Ancillary services** are, with respect to an In-Network health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by an Out-of-Network provider if there is no In-Network provider who can furnish such item or service at such facility.

**Cost sharing** means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Out-of-Network providers, or the cost of items or services that are not covered under the plan.

**Cost Sharing Amount** for Emergency and Non-emergency Services at In-Network Facilities performed by Out-of-Network Providers, and air ambulance services from Out-of-Network providers will be based on the Recognized Amount.

**Continuing Care Patient** means an individual who, with respect to a provider or facility -

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

**Emergency Medical Condition** means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

**Emergency Services** means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Out-of-Network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-Network provider may result in greater cost to the participant or beneficiary.

**Health Care Facility** (for non-emergency services) is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);

2. A hospital outpatient department;

3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

**Independent Freestanding Emergency Department** is a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

**No Surprises Act** means the federal No Surprises Act (Public Law 116-260, Division BB).

**Non-PPO emergency facility** means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

**Out-of-Network provider** means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

**Out-of-Network Rate** with respect to items and services furnished by an Out-of-Network provider, Out-of-Network emergency facility or Out-of-Network provider of ambulance services, means one of the following:

- The amount the parties negotiate;
- The amount approved under the independent dispute resolution (IDR) process; or
- If the state has an All-Payer Model Agreement, the amount that the state approves under that system.

**Qualifying Payment Amount (QPA)** means the amount calculated using the methodology described in 29 CFR 716-6(c).

**Recognized Amount** means (in order of priority) one of the following:

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

2. An amount determined by a specified state law; or

3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

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

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

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

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

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

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

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

# Arizona Pipe Trades Health and Welfare Trust Fund

OPEN ACCESS PLUS MEDICAL BENEFITS

**EFFECTIVE DATE:** April 1, 2025

Sample
3339909

This document printed in December, 2024 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

## Table of Contents

# Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "FUND" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT89

## Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

## The Schedule

**The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.**

# Special Plan Provisions

When you select a Participating Provider, this plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

**Services Available in Conjunction With Your Medical Plan**

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

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**Case Management**

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your fund, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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**Additional Programs**

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the

reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

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### Incentives to Participating Providers

Cigna continuously develops programs to help our customers access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna for providing care to members in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider's professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for utilizing or referring you to alternative sites of care as determined by your plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription drugs from Cigna affiliates. Such programs can help make you healthier, decrease your health care costs, or both. These programs are not intended to affect your access to the health care that you need. We encourage you to talk to your Participating Provider if you have questions about whether they receive financial incentives from Cigna and whether those incentives apply to your care.

HC-SPP85 01-24

### Care Management and Care Coordination Services

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

HC-SPP27 06-15
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## Important Notices

### Important Information

### Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Fund's or plan's behalf or for your benefit.

Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan's Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug Product benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

### Coupons, Incentives and Other Communications

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals and Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical and Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical

manufacturer or other third party represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.

For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug Product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.

**Specialty Prescription Drug Manufacturer Assistance and Support Benefit**

Certain Specialty Prescription Drugs on the Prescription Drug List have been classified as non-essential health benefits (NEHBs) and the cost of such NEHB Specialty Prescription Drugs will not be applied toward satisfying the Deductible and/or Out-of-Pocket Maximum. A list of these NEHB Specialty Prescription Drugs and the applicable Coinsurance for each NEHB Specialty Prescription Drug can be accessed at: www.saveonsp.com/cigna-NPF.

This list will change from time to time.

If you are prescribed one of these NEHB Specialty Prescription Drugs, you will be contacted by SaveOn SP, LLC ("SaveOnSP") and required to enroll in the applicable prescription drug manufacturer assistance or support program. Once enrolled, you provide SaveOnSP with consent to monitor your account. Any Coinsurance required for NEHB Specialty Prescription Drugs and/or any Coinsurance remaining after the available prescription drug manufacturer assistance is applied or is exhausted will be credited, and your Out-of-Pocket cost share will be reduced to $0.00. As a result of certain Specialty Prescription Drugs being classified as NEHB, your Coinsurance will continue to apply even after you have satisfied your plan's Deductible and/or Out-of-Pocket Maximum. In the event you fail to enroll in the applicable prescription drug manufacturer assistance or support program, or you do not provide consent to SaveOnSP to monitor your account, you will be responsible for the full required Coinsurance for the NEHB Specialty Prescription Drug without such payment applying to the Deductible and/or Out-of-Pocket Maximum. Your Coinsurance will continue to apply even after your Deductible and/or Out-of-Pocket Maximum has been satisfied.

In the event you enroll, or attempt to enroll, in the applicable/available prescription drug manufacturer assistance or support program and are denied any and all prescription drug manufacturer assistance or support due to a prescription drug manufacturer and/or legal restriction, the required Coinsurance for the NEHB Specialty Prescription Drugs will be credited and your Out-of-Pocket cost share will be reduced to $0.00, so long as you have given SaveOnSP consent to monitor your account.

HC-IMP385 01-25

**Discrimination is Against the Law**

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT96 07-17

**Proficiency of Language Assistance Services**

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish –** ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

**Arabic** – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese –** ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish –** UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شماره‌گیری کنید).

HC-NOT97 07-17

**Federal CAA - Consolidated Appropriations Act and TIC - Transparency in Coverage Notice**

Cigna will make available an internet-based self-service tool for use by individual customers, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Customers can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis.

Pursuant to Consolidated Appropriations Act (CAA), Section 106, Cigna will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS.

Subject to change based on government guidance for CAA Section 204, Cigna will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2) for a Fund without an integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.

HC-IMP353 01-24

**Federal CAA - Consolidated Appropriations Act**

**Continuity of Care**

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- undergoing a course of treatment for a serious and complex condition from the provider or facility.
- pregnant and undergoing treatment for the pregnancy from the provider or facility.
- undergoing a course of institutional or inpatient care from the provider or facility.
- scheduled to undergo non-elective surgery, including receipt of post-operative care with respect to such a surgery.
- determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

If applicable, Cigna will notify you of your continuity of care options.

**Appeals**

Any external review process available under the plan will apply to any adverse determination regarding claims subject to the No Surprises Act.

**Provider Directories and Provider Networks**

A list of network providers is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of providers, including Hospitals, of varied specialties as well as generic practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

A list of network pharmacies is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the No Surprises Act.

If you rely on a provider's in-network status in the provider directory or by contacting Cigna at the website or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then your plan cannot impose out-of-network cost shares to that covered service. In-network cost share must be applied as if the covered service were provided by an in-network provider.

**Direct Access to Obstetricians and Gynecologists**

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, access the website or call the phone number on your ID card.

**Selection of a Primary Care Provider**

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, access the website or call the phone number on your ID card.

**Your Rights and Protections Against Surprise Medical Bills**

When you get emergency care or are treated by an out-of-network provider at an in-network Hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

***What is "balance billing" (sometimes called "surprise billing")?***

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care – such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

***You are protected from balance billing for:***

- **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as a copayments, coinsurance, and deductibles). You cannot be balanced billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain non-emergency services at an in-network Hospital or ambulatory surgical center –** When you get services from an in-network Hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may not ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

**You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.**

**When balance billing is not allowed, you have these protections:**

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval in advance for services (also known as prior authorization).
  - Cover emergency services provided by out-of-network providers.
  - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits (EOB).
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

**If you think you have been wrongly billed,** contact Cigna at the phone number on your ID card. You can also contact No Surprises Help Desk at 1-800-985-3059 or www.cms.gov/nosurprises for more information about your rights under federal law.

HC-IMP383 01-25

**Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - Non-Quantitative Treatment Limitations (NQTLs)**

Federal MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

A description of your plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available by accessing the link at www.cigna.com/sp.

To determine which document applies to your plan, select the relevant health plan product; medical management model (inpatient only or inpatient and outpatient) which can be located in this booklet immediately following The Schedule; and pharmacy coverage (whether or not your plan includes pharmacy coverage).

HC-NOT137 01-24

## How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

**CLAIM REMINDERS**

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON

- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

**Timely Filing of Out-of-Network Claims**

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out- of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out- of-Network benefits, the claim will not be considered valid and will be denied.

**WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HC-CLM25 01-11
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# Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

**Opportunity to Select a Primary Care Physician**

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents. If you need assistance selecting your Primary Care Physician, please visit our website at www.cigna.com or call the number on the back of your ID Card.

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

**Changing Primary Care Physicians**

You may request a transfer from one Primary Care Physician to another by visiting our website at www.cigna.com or calling the number on the back of your ID Card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Direct Access For Mental Health and Substance Use Disorder Services

You are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder.

HC-IMP361 01-24

# Open Access Plus Medical Benefits

## The Schedule

**For You and Your Dependents**

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

**Important Notice on Mental Health and Substance Use Disorder Coverage**

Covered medical services received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to the Mental Health and Substance Use Disorder sections of The Schedule.

**Coinsurance**

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

**Copayments/Deductibles**

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

**Out-of-Pocket Expenses - For In-Network Charges Only**

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in The Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

# Open Access Plus Medical Benefits

## The Schedule

**Out-of-Pocket Expenses - For Out-of-Network Charges Only**

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Plan Deductible.
- Any copayments and/or benefit deductibles.

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments and/or benefit deductibles are no longer required.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Provider charges in excess of the Maximum Reimbursable Charge.

**Accumulation of Plan Deductibles**

Deductibles will accumulate in one direction (that is, Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

**Multiple Surgical Reduction**

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

**Assistant Surgeon and Co-Surgeon Charges**

**Assistant Surgeon**

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

**Co-Surgeon**

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

**Out-of-Network Charges for Certain Services**

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.
The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

# Open Access Plus Medical Benefits

## The Schedule

**Out-of-Network Emergency Services Charges**

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.
3. The allowable amount used to determine the Plan's benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

**Out-of-Network Air Ambulance Services Charges**

1. Covered air ambulance services are payable at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered air ambulance services rendered by an Out-of-Network provider is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Lifetime Maximum** | Unlimited | |
| **The Percentage of Covered Expenses the Plan Pays**<br><br>See Definitions section for an explanation of Maximum Reimbursable Charge.<br><br>**Note:**<br>"No charge" means an insured person is not required to pay Coinsurance. | 80% | 60% |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Calendar Year Deductible** | | |
| Individual | $1,000 per person | $1,000 per person |
| Family Maximum | $2,000 per family | $2,000 per family |
| Family Maximum Calculation<br>**Individual Calculation:**<br>Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance. | | |
| **Out-of-Pocket Maximum** | | |
| Individual | $4,800 per person | Unlimited |
| Family Maximum | $9,600 per family | Unlimited |
| Family Maximum Calculation<br>**Individual Calculation:**<br>Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%. | | |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Physician's Services** | | |
| Primary Care Physician's Office Visit | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Specialty Care Physician's Office Visits | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Consultant and Referral Physician's Services | | |
| **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company. | | |
| Surgery Performed in the Physician's Office | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Second Opinion Consultations (provided on a voluntary basis) | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Allergy Treatment/Injections | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Allergy Serum (dispensed by the Physician in the office) | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Convenience Care Clinic** (includes any related lab and x-ray services) | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Surgery | Same as surgery performed in a Primary Care Physician's office | Same as surgery performed in a Primary Care Physician's office |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Virtual Care**<br>**Dedicated Virtual Providers**<br>Dedicated virtual care services may be provided by MDLIVE, a Cigna affiliate.<br><br>Services available through contracted virtual providers as medically appropriate.<br><br>**Notes:**<br>• Primary Care cost share applies to routine care. Virtual wellness screenings are payable under preventive care.<br>• MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).<br>• Lab services supporting a virtual visit must be obtained through dedicated labs. | | |
| **MDLIVE Urgent Care Services** | 100% | In-Network coverage only |
| **MDLIVE Primary Care Services** | 100% | In-Network coverage only |
| **MDLIVE Specialty Care Services** | 100% | In-Network coverage only |
| **Virtual Physician Services**<br>Services available through Physicians as medically appropriate.<br>**Note:**<br>Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). | | |
| Physician Virtual Office Visit | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Preventive Care** | | |
| Routine Preventive Care - all ages | No charge | In-Network coverage only |
| Immunizations - all ages | No charge | In-Network coverage only |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Mammograms, PSA, PAP Smear** | | |
| Preventive Care Related Services (i.e. “routine” services) | No charge | In-Network coverage only |
| Diagnostic Related Services (i.e. “non-routine” services) | Subject to the plan’s x-ray & lab benefit; based on place of service | In-Network coverage only |
| **Inpatient Hospital – Facility Services** | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Semi-Private Room and Board | Limited to the semi-private room negotiated rate | Limited to the semi-private room rate |
| Private Room | Limited to the semi-private room negotiated rate | Limited to the semi-private room rate |
| Special Care Units (ICU/CCU) | Limited to the negotiated rate | Limited to the ICU/CCU daily room rate |
| **Outpatient Facility Services**<br>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Inpatient Hospital Physician’s Visits/Consultations** | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Inpatient Hospital Professional Services**<br>Surgeon<br>Radiologist<br>Pathologist<br>Anesthesiologist | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Outpatient Professional Services**<br>Surgeon<br>Radiologist<br>Pathologist<br>Anesthesiologist<br>**Note:** Plan deductible is waived for professional services by pathologist and radiologists. | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Urgent Care Services** | | |
| Physician's Office Visit | 80% | 80% of the Maximum Reimbursable Charge |
| Urgent Care Facility or Outpatient Facility | 80% | 80% of the Maximum Reimbursable Charge |
| Outpatient Professional Services (radiology, pathology, physician) | 80% | 80% of the Maximum Reimbursable Charge |
| X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit) | 80% | 80% of the Maximum Reimbursable Charge |
| Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) | 80% | 80% of the Maximum Reimbursable Charge |
| **Emergency Services** | | |
| Physician's Office Visit | 80% after plan deductible | 80% after plan deductible |
| Hospital Emergency Room | 80% after $100 per visit copay* and plan deductible<br>*waived if admitted | 80% charge after $100 per visit copay* and plan deductible<br>*waived if admitted |
| Outpatient Professional Services (radiology, pathology, ER physician) | 80% after plan deductible | 80% after plan deductible |
| X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit) | 80% | 80% of the Maximum Reimbursable Charge |
| Independent X-ray and/or Lab Facility in conjunction with an ER visit | 80% | 80% of the Maximum Reimbursable Charge |
| Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) | 80% | 80% of the Maximum Reimbursable Charge |
| **Air Ambulance** | 80% after plan deductible | 80% after plan deductible |
| **Ambulance** | 80% after plan deductible | 80% of the Maximum Reimbursable Charge after plan deductible |
| **Inpatient Services at Other Health Care Facilities**<br>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities<br>Calendar Year Maximum:<br>60 days combined | 80% after plan deductible | In-Network coverage only |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Laboratory Services** | | |
| Laboratory Services in a Physician's Office Visit | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Laboratory Services in an Outpatient Hospital Facility | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Laboratory Services in an Independent Lab Facility | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Radiology Services** | | |
| Radiology Services in a Physician's Office Visit | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Radiology Services in an Outpatient Hospital Facility | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)** | | |
| Physician's Office Visit | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Inpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Facility | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Outpatient Therapy Services**<br>Calendar Year Maximum:<br>50 days for all therapies combined<br>(The limit is not applicable to mental health conditions.)<br>Includes:<br>Cardiac Rehab<br>Physical Therapy<br>Speech Therapy<br>Occupational Therapy<br>Pulmonary Rehab<br>Cognitive Therapy<br>**Note:** Coverage review for Physical Therapy and Occupational Therapy begins after 25 visits. | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Chiropractic Care**<br>Calendar Year Maximum:<br>25 days | | |
| Physician's Office Visit | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Acupuncture** | | |
| Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a 20 day maximum per person per Calendar Year | | |
| Physician's Office Visit | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Home Health Care Services** | | |
| Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary) | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Hospice** | | |
| Inpatient Services | 100% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Services<br>(same coinsurance level as Home Health Care Services) | 100% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Bereavement Counseling** | | |
| Services provided as part of Hospice Care | | |
| Inpatient | 100% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient | 100% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Services provided by Mental Health Professional | Covered under Mental Health benefit | Covered under Mental Health benefit |
| **Medical Pharmaceuticals** | | |
| Inpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Cigna Pathwell Specialty Medical Pharmaceuticals | Cigna Pathwell Specialty Network provider:<br>80% after plan deductible<br>Non-Cigna Pathwell Specialty Network Providers:<br>Not Covered | In-Network coverage only |
| Other Medical Pharmaceuticals | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Gene Therapy**<br>Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary.<br><br>Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered. | | |
| Gene Therapy Product | Covered same as Medical Pharmaceuticals | In-Network coverage only |
| Inpatient Facility | 80% after plan deductible | In-Network coverage only |
| Outpatient Facility | 80% after plan deductible | In-Network coverage only |
| Physician's Services | 80% after plan deductible | In-Network coverage only |
| Travel Maximum:<br>$10,000 per episode of gene therapy | No charge (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy) | In-Network coverage only |
| **Advanced Cellular Therapy**<br>Includes prior authorized advanced cellular therapy products and related services when Medically Necessary. | | |
| Advanced Cellular Therapy Product | 80% after plan deductible | In-Network coverage only |
| Inpatient Facility | 80% after plan deductible | In-Network coverage only |
| Outpatient Facility | 80% after plan deductible | In-Network coverage only |
| Physician's Services | 80% after plan deductible | In-Network coverage only |
| Advanced Cellular Therapy Travel Maximum:<br>$10,000 per episode of advanced cellular therapy<br>(Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.) | No charge | In-Network coverage only |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Maternity Care Services** | | |
| Initial Visit to Confirm Pregnancy<br><br>**Note:**<br>OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company. | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) | 100% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist | 100% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Delivery - Facility<br>(Inpatient Hospital, Birthing Center) | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Abortion**<br>Includes only non-elective procedures | | |
| Physician's Office Visit | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Inpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Physician's Services | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Women's Family Planning Services** | | |
| Office Visits, Lab and Radiology Tests and Counseling | No charge | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Note:** Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office. | | |
| Surgical Sterilization Procedures for Tubal Ligation (excludes reversals) | | |
| Physician's Office Visit | No charge | 60% of the Maximum Reimbursable Charge after plan deductible |
| Inpatient Facility | No charge | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Facility | No charge | 60% of the Maximum Reimbursable Charge after plan deductible |
| Physician's Services | No charge | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Men's Family Planning Services** | | |
| Office Visits, Lab and Radiology Tests and Counseling | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Surgical Sterilization Procedures for Vasectomy (excludes reversals) | | |
| Physician's Office Visit | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Inpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Physician's Services | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Fertility Services** | | |
| Testing and treatment for Infertility. | Not Covered | Not Covered |
| **Note:** Medically Necessary treatment of an underlying medical condition is covered as any other illness under the plan. | | |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Transplant Services and Related Specialty Care**<br>Includes all medically appropriate, non-experimental transplants | | |
| Physician's Office Visit | 80% after plan deductible | In-Network coverage only |
| Inpatient Facility | 100% at LifeSOURCE center, otherwise 80% after plan deductible | In-Network coverage only |
| Physician's Services | 100% at LifeSOURCE center, otherwise 80% after plan deductible | In-Network coverage only |
| Lifetime Travel Maximum: $10,000 per transplant | No charge (only available when using LifeSOURCE facility) | In-Network coverage only |
| **Durable Medical Equipment** | | |
| Calendar Year Maximum: Unlimited | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Outpatient Dialysis Services** | | |
| Physician's Office Visit | 80% | In-Network coverage only |
| Outpatient Facility Services | 80% after plan deductible | In-Network coverage only |
| Physician's Services | 80% after plan deductible | In-Network coverage only |
| Home Setting | 80% after plan deductible | In-Network coverage only |
| **Breast Feeding Equipment and Supplies**<br>**Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies. | No charge | 60% of the Maximum Reimbursable Charge after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **External Prosthetic Appliances**<br>Calendar Year Maximum:<br>Unlimited<br><br>**Note:** Includes Cranial banding/cranial orthoses and other similar devices when medically necessary. | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Nutritional Counseling**<br>Calendar Year Maximum:<br>3 visits; the visit limit does not apply to treatment of diabetes and to mental health and substance use disorder conditions. | | |
| Physician's Office Visit | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Inpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Physician's Services | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Genetic Counseling**<br>Calendar Year Maximum:<br>3 visits for counseling, pre- and post-genetic testing; however, the 3 visit limit will not apply to mental health and substance use disorder conditions. | | |
| Physician's Office Visit | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Inpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Physician's Services | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Dental Care**<br>Limited to charges made for a continuous course of dental treatment for an Injury to teeth. | | |
| Physician's Office Visit | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Inpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Physician's Services | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **TMJ Surgical and Non-Surgical**<br>Includes appliances and orthodontic treatment subject to medical necessity. | | |
| Physician's Office Visit | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Inpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Outpatient Facility | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| Physician's Services | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Non Surgical TMJ Services**<br>(surgical services will be covered same as any other illness)<br>Lifetime Maximum:<br>$5,000 | | |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Bariatric Surgery**<br><br>**Note:**<br>Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate. | | |
| Physician's Office Visit | 80% after plan deductible | In-Network coverage only |
| Inpatient Facility | 80% after plan deductible | In-Network coverage only |
| Outpatient Facility | 80% after plan deductible | In-Network coverage only |
| Physician's Services | 80% after plan deductible | In-Network coverage only |
| **Hearing Aids**<br><br>Calendar Year Maximum:<br><br>$1,300 maximum every 36 months. Maximum of 2 devices every 36 months.<br><br>**Note:** Includes testing and fitting of hearing aid devices covered at the PCP or Specialist Office visit level. | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Orthotics**<br><br>**Note:** Includes custom made foot orthotics and corrective appliances (Including Prosthetic devices and Orthotic devices) | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Wigs**<br><br>Calendar Year Maximum:<br>$200<br><br>**Note:** Coverage is for hair loss due to cancer treatment. | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |
| **Routine Foot Disorders** | Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary | Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Mental Health** | | |
| **Inpatient**<br>Includes Acute Inpatient and Residential Treatment<br><br>Calendar Year Maximum: Unlimited | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible<br><br>**Note:**<br>Inpatient Residential Treatment is not covered out-of-network |
| **Outpatient** | | |
| Outpatient - Office Visits<br>Includes individual, family and group psychotherapy; medication management, virtual care, etc.<br><br>Calendar Year Maximum: Unlimited | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Dedicated Virtual Providers MDLIVE Behavioral Services | No charge after the $10 per visit copay | In-Network coverage only |
| Outpatient - All Other Services<br>Includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), Transcranial Magnetic Stimulation (TMS), etc.<br><br>Calendar Year Maximum: Unlimited | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Substance Use Disorder** | | |
| **Inpatient**<br>Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment<br><br>Calendar Year Maximum: Unlimited | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible<br><br>**Note:**<br>Inpatient Residential Treatment is not covered out-of-network |
| **Outpatient** | | |
| Outpatient - Office Visits<br>Includes individual, family and group psychotherapy; medication management, virtual care, etc.<br><br>Calendar Year Maximum: Unlimited | 80% | 60% of the Maximum Reimbursable Charge after plan deductible |
| Dedicated Virtual Providers MDLIVE Behavioral Services | No charge after the $10 per visit copay | In-Network coverage only |
| Outpatient - All Other Services<br>Includes Outpatient Detoxification, Partial Hospitalization, Intensive Outpatient Services, etc.<br><br>Calendar Year Maximum: Unlimited | 80% after plan deductible | 60% of the Maximum Reimbursable Charge after plan deductible |

# Open Access Plus Medical Benefits

## Certification Requirements - Out-of-Network

**For You and Your Dependents**

**Pre-Admission Certification/Continued Stay Review for Hospital Confinement**

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for Mental Health or Substance Use Disorder Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will not include the first $250 of Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Room and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

**Outpatient Procedures**

Including, but not limited to:

- Medical Pharmaceuticals.
- Radiation Therapy.

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## Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- home infusion therapy.
- private duty nursing.
- medical injectables.
- radiation therapy.
- medical oncology.
- gene therapy services.
- inpatient transplant services.

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## Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- preventive care services; and
- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

**Covered Expenses**

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges by a Physician or a Psychologist for professional services.
- charges by a Nurse for professional nursing service.
- charges for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges for diagnosis and treatment of: corns, calluses, flat feet, chronic foot strain or instability or imbalance of the feet, and toenail maintenance.
- charges for screening prostate-specific antigen (PSA) testing.
- charges for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges for abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- charges for Men's family planning, counseling, testing and sterilization (e.g. vasectomies), excluding reversals.
- charges for the following preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;

- the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
- with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

- charges for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.
- charges for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- charges for acupuncture.
- charges for hearing aids and associated exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges for services related to gender affirmation, including behavioral counseling, hormone therapy, genital reconstructive surgical procedures, and chest reconstructive surgical procedures.

**Virtual Care**

**Dedicated Virtual Providers**

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring by dedicated virtual providers as medically appropriate through audio, video and secure internet-based technologies.

Includes charges for the delivery of mental health and substance use disorder-related services, consultations, and remote monitoring by dedicated virtual providers as appropriate through audio, video and secure internet-based technologies.

**Virtual Physician Services**

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring as medically appropriate through audio, video and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

**Convenience Care Clinic**

Convenience Care Clinics provide for common ailments and routine services, including but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

**Genetic Counseling**

Charges for genetic counseling for an individual who is undergoing genetic testing or is a potential candidate for genetic testing. May be performed prior to and/or following the genetic test.

**Nutritional Counseling**

Charges for nutritional counseling when diet is a part of the medical management of a medical or behavioral condition.

**Enteral Nutrition**

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism).

**Internal Prosthetic/Medical Appliances**

Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

HC-COV1466 01-25

**Home Health Care Services**

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.
- the patient's home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as physical therapist, occupational therapist and speech therapist.
- services of a home health aide when provided in direct support of those nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

HC-COV1123 01-22

**Hospice Care Services**

Charges for services for a person diagnosed with advanced illness having a life expectancy of twelve or fewer months. Services provided by a Hospice Care Program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies.

Hospice Care Programs rendered by Hospice Facilities or Hospitals include services:

- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;

Hospice Care Programs rendered by Other Health Care Facilities or in the Home include services:

- for part-time or intermittent nursing care by or under the supervision of a Nurse;
- for part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- laboratory services;

but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- services for any period when you or your Dependent is not under the care of a Physician;
- services or supplies not listed in the Hospice Care Program;
- to the extent that any other benefits are payable for those expenses under the policy;
- services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV1180 01-22

**Mental Health and Substance Use Disorder Services**

The plan covers charges for mental health and substance use disorder services.

**Mental Health Disorders** are conditions which consider the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- a behavioral or psychological syndrome or pattern that occurs in an individual.
- reflects an underlying psychobiological dysfunction.

- the consequences of which are clinically significant distress (such as a painful symptom) or disability (such as impairment in one or more important areas of functioning).
- must not be merely an expected response to common stressors and losses (such as loss of a loved one) or a culturally sanctioned response to a particular event (such as trance states in religious rituals).
- primarily a result of social deviance or conflicts with society.

**Substance Use Disorders** involve patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects, considering the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- using more of a substance than intended or using it for longer than a person is meant to use it.
- trying to cut down or stop using the substance, but unable to do so.
- experiencing intense cravings or urges to use the substance.
- needing more of the substance to get a desired effect, also referred to as tolerance.
- developing withdrawal symptoms when not using the substance.
- spending more time getting and using drugs and recovering from substance use.
- neglecting responsibilities at home, work, or school because of substance use.
- continuing to use the substance despite the substance causing problems to physical or mental health.
- giving up important or desirable social and recreational activities due to substance use.
- using substances in risky settings that put you or your Dependent in danger.

**Inpatient Mental Health Services (including Mental Health Acute Inpatient Services and Mental Health Residential Treatment Services)**

**Mental Health Acute Inpatient Services** are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Mental Health Disorder.

**Mental Health Residential Treatment Services** are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

**Mental Health Residential Treatment Center** means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Mental Health Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Mental Health Residential Treatment Center.

**Outpatient Mental Health Services (including Mental Health Partial Hospitalization and Mental Health Intensive Outpatient Services)**

**Outpatient Mental Health Services** are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Mental Health Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Mental Health Residential Treatment Center, for evaluation and treatment of a Mental Health Disorder.

**Mental Health Partial Hospitalization Services** are active, time-limited, ambulatory mental health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Mental Health Disorders, similar in intensity to that provided in an Inpatient Hospital or Mental Health Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

**Mental Health Intensive Outpatient Services** are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Mental Health Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

**Inpatient Substance Use Disorder Services (including Acute Inpatient Detoxification, Substance Use Disorder Inpatient Rehabilitation, Substance Use Disorder Residential Treatment Services)**

**Acute Inpatient Detoxification Services** are services provided by a Hospital or Substance Use Disorder Residential Treatment Center for around-the-clock, intensive management and monitoring of individuals requiring acute detoxification as the initial phase of evaluation and treatment for a Substance Use Disorder.

**Substance Use Disorder Inpatient Treatment Services** are services provided by a Hospital while you or your Dependent

are Confined in a Hospital for evaluation and treatment of an acute Substance Use Disorder.

**Substance Use Disorder Residential Treatment Services** are services provided by a Hospital or Substance Use Disorder Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for evaluation and treatment of a subacute Substance Use Disorder.

**Substance Use Disorder Residential Treatment Center** means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Substance Use Disorder Residential Treatment Center.

**Outpatient Substance Use Disorder Rehabilitation Services (including Outpatient Detoxification, Substance Use Disorder Partial Hospitalization, and Substance Use Disorder Intensive Outpatient Services)**

**Outpatient Substance Use Disorder Services** are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Substance Use Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Substance Use Disorder Residential Treatment Center, for evaluation and treatment of a Substance Use Disorder.

**Substance Use Disorder Partial Hospitalization Services** are active, time-limited, ambulatory substance use disorder treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Substance Use Disorders, similar in intensity to that provided in an Inpatient Hospital or Substance Use Disorder Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

**Substance Use Disorder Intensive Outpatient Services** are active, time-limited, ambulatory substance use disorder treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Substance Use Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

**Substance Use Disorder Detoxification Services** are services provided for daily, active comprehensive management and monitoring of individuals requiring detoxification as part of evaluation and treatment of a Substance Use Disorder, but that do not require a person to be Confined in a Hospital or Substance Use Disorder Residential Treatment Center.

HC-COV1476 01-24

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**Durable Medical Equipment**

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets, that emit Ultraviolet A (UVA) rays sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

HC-COV1124 02-21

**External Prosthetic Appliances and Devices**

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices include prostheses/prosthetic appliances and devices; orthoses and orthotic devices; braces; and splints.

**Prostheses/Prosthetic Appliances and Devices**

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial prostheses.

**Orthoses and Orthotic Devices**

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot orthoses primarily for improved athletic performance or sports participation.

**Braces**

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

**Splints**

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older.
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements for external prosthetic devices; or
- microprocessor controlled prostheses and orthoses; and
- myoelectric prostheses and orthoses.

**Outpatient Therapy Services**

Charges for the following therapy services:

**Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy**

- Charges for therapy services are covered when provided as part of a program of treatment.

**Cardiac Rehabilitation**

- Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

  Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

**Chiropractic Care Services**

- Charges for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called "rehabilitative"):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Sickness, Injury, or loss of a body part.
- Improve, adapt or attain function (sometimes called "habilitative"):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an Injury or Sickness.

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status.
- charges for Chiropractic Care not provided in an office setting.
- vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.



**Breast Reconstruction and Breast Prostheses**

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

**Reconstructive Surgery**

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ

disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV631 12-17

**Transplant Services and Related Specialty Care**

Charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures are also covered for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO) ventricular assist device (VAD) and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are not covered.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

**Transplant and Related Specialty Care Travel Services**

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a preapproved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from, the designated Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant, the transplant recipient's plan would cover all donor costs.

HC-COV1328 04-23

**Advanced Cellular Therapy**

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the In-Network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

**Advanced Cellular Therapy Travel Services**

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within a 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1327 04-23

**Medical Pharmaceuticals**

The plan covers charges made for Medical Pharmaceuticals that may be administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals that, because of their characteristics as determined by Cigna, require a qualified licensed health care professional to administer or directly supervise administration.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive coverage, the covered person may be required to try a specific Medical Pharmaceutical before trying others. Medical Pharmaceuticals administered in an Inpatient facility are reviewed per Inpatient review guidelines.

Cigna determines the utilization management requirements and other coverage conditions that apply to a Medical Pharmaceutical by considering a number of factors:

- Clinical factors, which may include Cigna's evaluations of the site of care and the relative safety or relative efficacy of Medical Pharmaceuticals.
- Economic factors, which may include the cost of the Medical Pharmaceutical and assessments of cost effectiveness after rebates.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include an increase in the cost of a Medical Pharmaceutical.

Certain Medical Pharmaceuticals that are used for treatment of complex chronic conditions, are high cost, and are administered and handled in a specialized manner may be subject to additional coverage criteria or require administration by a participating provider in the network for the Cigna Pathwell Specialty Network. Cigna determines which injections, infusions, and implantable drugs are subject to these criteria and requirements.

The Cigna Pathwell Specialty Network includes contracted physician offices, ambulatory infusion centers, home and outpatient hospital infusion centers, and contracted specialty pharmacies. When the Cigna Pathwell Specialty Network cannot meet the clinical needs of the customer as determined by Cigna, exceptions are considered and approved when appropriate.

A complete list of those Medical Pharmaceuticals subject to additional coverage criteria or that require administration by a participating provider in the Cigna Pathwell Specialty Network is available at www.cigna.com/PathwellSpecialty.

The following are not covered under the plan:

- Medical Pharmaceutical regimens that have a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s);
- Medical Pharmaceuticals newly approved by the Food & Drug Administration (FDA) up to the first 180 days following its market launch;
- Medical Pharmaceutical regimens for which there is an appropriate lower cost alternative for treatment.

In the event a covered Medical Pharmaceutical is not clinically appropriate, Cigna makes available an exception process to allow for access to non-covered drugs when Medically Necessary.

Cigna may consider certain Medical Pharmaceutical regimens as preferred when they are clinically effective treatments and the most cost effective. Preferred regimens are covered unless the covered person is not a candidate for the regimen and a Medical Necessity coverage exception is obtained.



**Gene Therapy**

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

**Gene Therapy Travel Services**

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with

Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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**Clinical Trials**

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Health Care Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
  - any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
    - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
    - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
  - the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
  - the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.
  - an item or service that is not used in the direct clinical management of the individual.
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train.
  - mileage reimbursement for driving a personal vehicle.
  - lodging.
  - meals.

- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- the clinical trial is conducted outside the individual's state of residence.

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## Prescription Drug Benefits

### The Schedule

**For You and Your Dependents**

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

You and your Dependents will pay 100% of the cost of any Prescription Drug Product excluded from coverage under this plan. The amount you and your Dependent pays for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.

**Coinsurance**

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product dispensed by a Network Pharmacy, and it means the percentage of the benchmark price used by Cigna for a covered Prescription Drug Product dispensed by a non-Network Pharmacy, that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

**Out-of-Pocket Expenses**

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drug Products for which the Plan provides no payment because of the Coinsurance factor and any Copayments or Deductibles. When the Out-of-Pocket Maximum shown in The Schedule is reached, benefits are payable at 100%.

| BENEFIT HIGHLIGHTS | NETWORK PHARMACY | NON-NETWORK PHARMACY |
|---|---|---|
| **Patient Assurance Program**<br>Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above.<br><br>For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any.<br><br>Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum.<br><br>Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum.<br><br>Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card. | | |
| **Out-of-Pocket Maximum** | | |
| Individual | $2350 per person | Not Applicable |
| Family | $4700 per family | Not Applicable |
| **Maintenance Drug Products**<br>Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Pharmacy or home delivery Pharmacy. | | |
| Certain Preventive Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required. | | |

| BENEFIT HIGHLIGHTS | NETWORK PHARMACY | NON-NETWORK PHARMACY |
|---|---|---|
| **Prescription Drug Products at Retail Pharmacies** | **The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy** | **The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy** |
| Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy. | | |
| **Tier 1**<br>Generic Drugs on the Prescription Drug List | 20%, subject to a maximum of $10, then the Plan pays 100% | 40% |
| **Tier 2**<br>Brand Drugs designated as preferred on the Prescription Drug List | 20% | 40% |
| **Tier 3**<br>Brand Drugs designated as non-preferred on the Prescription Drug List | 20% | 40% |
| **Tier 4**<br>Brand Drugs designated as Specialty Prescription Drug Products on the Prescription Drug List | 20%, subject to a maximum of $100, then the Plan pays 100% | 40% |
| **Prescription Drug Products at Retail Designated Pharmacies** | **The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy** | **The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy** |
| Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy. | | |
| Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill. | | |
| Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill. | | |
| **Tier 1**<br>Generic Drugs on the Prescription Drug List | 20%, subject to a maximum of $10, then the Plan pays 100% | 40% |
| **Tier 2**<br>Brand Drugs designated as preferred on the Prescription Drug List | 20% | 40% |

| BENEFIT HIGHLIGHTS | NETWORK PHARMACY | NON-NETWORK PHARMACY |
|---|---|---|
| **Tier 3**<br>Brand Drugs designated as non-preferred on the Prescription Drug List | 20% | 40% |
| **Tier 4**<br>Brand Drugs designated as Specialty Prescription Drug Products on the Prescription Drug List | Specialty Prescription Drug Products are limited to up to a consecutive 30 day supply per Prescription Order or Refill. | Specialty Prescription Drug Products are limited to up to a consecutive 30 day supply per Prescription Order or Refill. |
| **Prescription Drug Products at Home Delivery Pharmacies** | **The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy** | **The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy** |
| Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to retail Pharmacies. | | |
| **Tier 1**<br>Generic Drugs on the Prescription Drug List | 10%, subject to a maximum of $10, then the Plan pays 100% | In-network coverage only |
| **Tier 2**<br>Brand Drugs designated as preferred on the Prescription Drug List | 45%, subject to a maximum of $45, then the Plan pays 100% | In-network coverage only |
| **Tier 3**<br>Brand Drugs designated as non-preferred on the Prescription Drug List | 65%, subject to a maximum of $65, then the Plan pays 100% | In-network coverage only |
| **Tier 4**<br>Brand Drugs designated as Specialty Prescription Drug Products on the Prescription Drug List | 20%, subject to a maximum of $100, then the Plan pays 100%<br><br>Specialty Prescription Drug Products are limited to up to a consecutive 30 day supply per Prescription Order or Refill. | In-network coverage only |

# Prescription Drug Benefits

## Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List that are dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

**Prescription Drug List Management**

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

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## Limitations

Your plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a participating Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the participating Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.

**Prior Authorization Requirements**

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without

limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.

**Step Therapy**

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

**Supply Limits**

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

**Specialty Prescription Drug Products**

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products.

**Designated Pharmacies**

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Prescription Drug Product or be subject to the non-Network Pharmacy Benefit, if any, for that Prescription Drug Product. Refer to The Schedule for further information.

**New Prescription Drug Products**

New Prescription Drug Products may or may not be placed on a Prescription Drug List tier upon market entry. Cigna will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. Cigna's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim,

the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

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## Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

**Coinsurance**

Your plan requires that you pay a Coinsurance amount for covered Prescription Drug Products as set forth in The Schedule. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Coinsurance requirement will be the lowest of the following amounts:

- the amount that results from applying the applicable Coinsurance percentage set forth in The Schedule to the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

**Payments at Non-Network Pharmacies**

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a non-Network Pharmacy shall be determined by applying any applicable Deductible, non-Network Pharmacy Coinsurance amount, or other cost-sharing amount set forth in The Schedule to the benchmark price Cigna uses, for a Prescription Drug Product dispensed by a non-Network Pharmacy. Any reimbursement due to you for a covered Prescription Drug Product dispensed by a non-Network Pharmacy will not exceed the benchmark price applied by Cigna for a Prescription Drug Product, less any applicable Deductible, Coinsurance, or other cost-sharing payment you owe.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

HC-PHR727 01-25

## Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce

wrinkles, medications used to promote hair growth and fade cream products.

- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are not FDA-approved for any indication.
- Prescription Drug Products classified as gene therapy.

HC-PHR719 01-25

## Reimbursement/Filing a Claim

**Retail Pharmacy**

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan or wish to dispute the amount you were charged. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product. If you believe that the amount of any applicable Copayment, Coinsurance and/or Deductible you were charged was incorrect, to dispute the accuracy of the amount you were charged you must submit a claim for reimbursement according to the applicable claim filing procedures for postservice claims.

When you purchase a covered Prescription Drug Product dispensed by a non-Network Pharmacy, then you must pay the non-Network Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-PHR728 01-25

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

**Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan:**

- care for health conditions that are required by state or local law to be treated in a public facility.

- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
  - any instance where Cigna determines that a provider or Pharmacy did not bill you for or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
  - charges of a non-Participating Provider who has agreed to charge you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

  In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
  - require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
  - deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
  - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.

  Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- charges or payment for healthcare-related services that violate state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be either:
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications except as may be covered under the “Reconstructive Surgery” benefit: abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and

extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are covered.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction, anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan, except that expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness as defined in the Open Access Plus Medical Plan Benefits chapter of this Article XV.
- non-medical counseling and/or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and, rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- non-medical living arrangements, including but not limited to, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, or supportive living programs.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Care Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids, including but not limited to elastic stockings, garter belts, corsets and dentures.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames, contact lenses and associated services (exams and fittings) (except for the initial set after treatment of keratoconus or following cataract surgery).

- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- health and beauty aids, cosmetics and dietary supplements.
- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- massage therapy.
- products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products and supplies include but are not limited to therapeutic Continuous Glucose Monitor (CGM) sensors and transmitters and insulin pods.
- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.
- expenses incurred by a participant to the extent reimbursable under automobile insurance coverage. Coverage under this plan is secondary to automobile no-fault insurance or similar coverage. The coverage provided under this plan does not constitute "Qualified Health Coverage" under Michigan law and therefore does not replace Personal Injury Protection (PIP) coverage provided under an automobile insurance policy issued to a Michigan resident. This plan will cover expenses only not otherwise covered by the PIP coverage.

### General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for any charges related to care provided through a public program, other than Medicaid.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's family.
- for expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.

HC-EXC582 M 01-25

## Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

## Definitions

For the purposes of this section, the following terms have the meanings set forth below:

**Plan**

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

**Closed Panel Plan**

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

**Primary Plan**

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

**Secondary Plan**

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

**Allowable Expense**

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

**Reasonable Cash Value**

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

## Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an Member shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Member;

- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active Member (or as that Member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired Member (or as that Member's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active Member or retiree (or as that Member's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

**Effect on the Benefits of This Plan**

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans are not more than 100% of the total of all Allowable Expenses.

**Recovery of Excess Benefits**

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare Plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

**Right to Receive and Release Information**

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

**Coordination of Benefits with Medicare**

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don’t elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- COBRA or State Continuation: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- Retirement or Termination of Employment: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Member, and your Fund has fewer than 100 members.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Member, and your Fund has fewer than 20 members.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Member. This Plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Member, and your Fund has 100 or more members.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Member, and your Fund has 20 or more members.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Member. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

**IMPORTANT: If you, your spouse, or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.**

**Failure to Enroll in Medicare**

If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA, state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

**Assistance with Medicare Questions**

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

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# Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault insurance or similar coverage.

**Subrogation/Right of Reimbursement**

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether

by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

**Lien of the Plan**

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

**Additional Terms**

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB128 03-20

# Payment of Benefits

**Assignment and Payment of Benefits**

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of

your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

**Recovery of Overpayment**

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

**Calculation of Covered Expenses**

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

HC-POB132 01-19

# Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

## Notice of Provider Directory/Networks

**Notice Regarding Provider Directories and Provider Networks**

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

**Notice Regarding Pharmacy Directories and Pharmacy Networks**

A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10

## Qualified Medical Child Support Order (QMCSO)

### Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Fund and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

### Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy or health plan to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

### Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

## Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Fund for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Member only; spouse only; Member and spouse; Dependent child(ren) only; Member and Dependent child(ren); Member, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Member due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Member;

- termination of employment;
- reduction in work hours to below the minimum required for eligibility;
- you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
- you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.

- **Termination of Fund contributions (excluding continuation coverage).** If a current or former Fund ceases all contributions toward the Member's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Fund or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Fund's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

**See the Eligibility Article for information on enrolling a Dependent under Special Enrollment.**

Domestic Partners and their children (if not legal children of the Member) are not eligible for special enrollment.

HC-FED96 04-17

## Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11 10-10

## Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

HC-FED12 10-10

## Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

**Continuation of Health Insurance During Leave**

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Member under the terms of that Act.

See the Eligibility Article for more information on FMLA.

## Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Member's military leave of absence. See the Eligibility Article for more information on USERRA leave.

## Claim Determination Procedures under ERISA

**The following complies with federal law. Provisions of applicable laws of your state may supersede.**

**Procedures Regarding Medical Necessity Determinations**

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the booklet, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the booklet, in your provider's network participation documents as applicable, and in the determination notices.

Note: An oral statement made to you by a representative of Cigna or its designee that indicates, for example, a particular service is a Covered Expense, is authorized for coverage by the plan, or that you are eligible for coverage is not a guarantee that you will receive benefits for services under this plan. Cigna will make a benefit determination after a claim is received from you or your authorized representative, and the benefit determination will be based on, your eligibility as of the date services were rendered to you and the terms and conditions of the plan in effect as of the date services were rendered to you.

**Preservice Determinations**

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will

defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative attempts to request a preservice determination, but fails to follow Cigna's procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

**Concurrent Determinations**

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

**Postservice Determinations**

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

**Notice of Adverse Determination**

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED104 01-19

## Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or

- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

HC-FED88 01-17

## Medical - When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you", "your", or "Member" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted.

We want you to be completely satisfied with the care and services you receive. That is why we have established a process for addressing your concerns and solving your problems.

**Start With Member Services**

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

**Appeals Procedure**

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal of an adverse benefit determination, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

**Level-One Appeal**

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

Cigna's reviewer, in consultation with the treating health care provider, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

**Level-Two Appeal**

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal except send this appeal to the Board of Trustees who will administer the level-two process.

Arizona Pipe Trades Health and Welfare Fund c/o
BeneSys, Inc.
3121 N. 24th Street
Phoenix, AZ 85016
877-429-7473

For required preservice and concurrent care coverage determinations, the Board review will be completed within 15 calendar days, and for post service claims, the Board review

will be completed no later than the first meeting following the Board's receipt of the appeal, unless the Board received the appeal within 30 days prior to that meeting, in which case the Board will decide your appeal no later than the second meeting following receipt of the request for review. If special circumstances require a further extension of time for processing, the Board will decide the appeal no later than the third meeting following receipt by the Board of your request for review. If such an extension of time for review is required because of special circumstances, the Board will notify you in writing of the extension, describing the special circumstances and any additional information needed by the Board to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna or the Board in connection with the level-two appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the Board's decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Board, the Board will provide the rationale to you as soon as possible and sufficiently in advance of its decision so that you will have an opportunity to respond.

You will be notified in writing of the Board's decision within 5 business days after the Board meeting, and within the Board review time frames above if the Board does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider, would cause you severe pain which cannot be managed without the requested services. Cigna's reviewer, in consultation with the treating health care provider, will decide if an expedited appeal is necessary. When an appeal is expedited, the Board will respond orally with a decision within 72 hours, followed up in writing.

**Independent Review Procedure**

Any independent review procedure available under the plan will apply to any adverse determination regarding whether the plan complied with the surprise billing and cost sharing protections of the federal No Surprises Act and its implementing regulations.

If you are not fully satisfied with the decision of the level-two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare, or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. Cigna and the Board will abide by the decision of the Independent Review Organization.

To request a review, you must notify Cigna or the Board within 180 days of your receipt of the level-two appeal review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

**Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: availability, upon request, of the diagnosis and treatment codes, and their meanings including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

### Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

### Legal Action

Because your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action. However, no action may be brought at all unless brought within three years after proof of claim is required under the plan. However, no action may be brought at all unless brought within three years after a claim is submitted for In-Network services, or within three years after proof of claim is required under the plan for Out-of-Network services.

HC-FED123 M 01-25

## COBRA Continuation Rights Under Federal Law

### For You and Your Dependents

### What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan.

See the chapter on Self-Payment Provisions and COBRA Information for more information on COBRA rights.

# Definitions

### Active Service

You will be considered in Active Service:

- on any of your Fund's scheduled work days if you are performing the regular duties of your work as determined by your Fund on that day either at your Fund's place of business or at some location to which you are required to travel for your Fund's business.
- on a day which is not one of your Fund's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1095 12-17

### Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

HC-DFS1480 01-21

### Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

HC-DFS1553 01-21

### Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS840 10-16

### Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS841 10-16

### Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

HC-DFS842 10-16

### Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to effect changes regarding coverage treatment of Prescription Drug Products and Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Prescription Drug Products and Medical Pharmaceuticals.

HC-DFS1494 07-20

### Charges

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

HC-DFS1193 01-19

### Chiropractic Care

The term Chiropractic Care means the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS1717 01-22

### Convenience Care Clinics

Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

HC-DFS1629 07-21

### Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person’s current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS1894 01-24

### Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Member will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Member coverage. A child under age 26 may be covered as either an Member or as a Dependent child. You cannot be covered as an Member while also covered as a Dependent of an Member.

No one may be considered as a Dependent of more than one Member.

HC-DFS1718 01-22

**Designated Pharmacy**

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. A Pharmacy that is a Network Pharmacy is not necessarily a Designated Pharmacy.

HC-DFS1614 01-22

**Emergency Medical Condition**

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 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; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS1766 01-23

**Emergency Services**

Emergency Services means, with respect to an Emergency Medical Condition:

- a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition.
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or emergency department, as are required to Stabilize the patient (regardless of the Hospital department in which further examination or treatment is provided).
- after the patient is Stabilized, services rendered by an Out-of-Network provider, Hospital or facility (regardless of the Hospital department that provides the services) as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are provided.

However, such post-Stabilization services are not considered Emergency Services if the attending provider determines the patient is able to travel using non-medical or non-emergency transportation to an available In-Network location within reasonable travel distance and applicable state and federal notice and consent requirements are met.

HC-DFS1905 01-25

**Essential Health Benefits**

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following 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.

HC-DFS411 01-11

**Expense Incurred**

An expense is incurred when the service or the supply for which it is incurred is provided.

HC-DFS10 04-10
V1

**Free-Standing Surgical Facility**

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;

- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

HC-DFS1484 01-21

**Fund**

The term Fund means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services. The term Employer means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance.

HC-DFS1615 M 01-22

**Generic Drug**

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a "brand name" drug by the manufacturer, Pharmacy or your Physician.

HC-DFS846 10-16

**Hospice Care Program**

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51 04-10 V1

**Hospice Care Services**

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10 V1

**Hospice Facility**

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53 04-10 V1

**Hospital**

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or

- an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital does not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS1485 01-21

**Hospital Confinement or Confined in a Hospital**

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HC-DFS807 12-15

**Injury**

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

**Maintenance Drug Product**

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long- term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

HC-DFS847 10-16

**Maintenance Treatment**

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

**Maximum Reimbursable Charge – Medical**

The Maximum Reimbursable Charge applies to Out-of-Network services other than those described in the Medical Schedule for Certain Services, Out-of-Network Emergency Services Charges, and Out-of-Network Air Ambulance Services Charges.

The Maximum Reimbursable Charge (also referred to as MRC) is the maximum amount that your plan will pay an Out-of-Network health care provider for a Covered Expense. Your applicable Out-of-Network Coinsurance and/or Deductible amount(s), if any, set forth in The Schedule are determined based on the MRC. Unless prohibited by applicable law or agreement, Out-of-Network providers may also bill you for the difference between the MRC and their charges, and you may be financially responsible for that amount. If you receive a bill from an Out-of-Network provider for more than the What I Owe amount on the Explanation of Benefits (EOB), please call Cigna at the phone number on your ID card.

If an Out-of-Network provider is willing to agree to a rate that Cigna, in its discretion, determines to be market competitive, then that rate will become the MRC used to calculate the Out-of-Network allowable amount for a Covered Expense. An Out-of-Network provider can agree to a rate by: (i) entering into an agreement with Cigna or one of Cigna's third-party vendors that establishes the rate the Out-of-Network provider is willing to accept as payment for the Out-of-Network Covered Expense; or (ii) receiving a payment from Cigna based on an allowed amount that Cigna or one of Cigna's third-party vendors has determined is a market competitive rate without billing you and/or obligating you to pay the difference between the payment amount and the charged amount.

If an Out-of-Network provider does not agree to a market competitive rate as described in the previous paragraph, then the MRC for Open Access Plus will be based on an amount required by law, or if no amount is required by law, then the lesser of:

- the providers normal charge for a similar service or supply; or
- the plan holder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service or supply within the geographic market. In the event that Medicare does not have a published rate for a particular service or supply, Cigna may, in its discretion, determine the MRC based on a rate for the same or similar service or supply by applying a Medicare-based methodology that Cigna deems appropriate.

The percentage used to determine the Maximum Reimbursable Charge is 150%.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

HC-DFS1853 01-24

**Medicaid**

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10
V1

**Medical Pharmaceutical**

Medical Pharmaceuticals are used for treatment of complex chronic conditions, are administered and handled in a specialized manner, and may be high cost. Because of their characteristics, they require a qualified Physician to administer or directly supervise administration. Some Medical Pharmaceuticals may initially or typically require Physician oversight but subsequently may be self-administered under certain conditions specified in the product's FDA labeling.

HC-DFS1722 07-22

**Medically Necessary/Medical Necessity**

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director relies on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1896 01-25

### Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17 04-10
V1

### Member

The term Member means a member in good standing of the Arizona Pipe Trade Health and Welfare Trust Fund.

### Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

HC-DFS1488 01-21

### Network Pharmacy

A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under your Fund’s plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

HC-DFS1198 01-19

### New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

HC-DFS1498 07-20

### Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22 04-10
V1

### Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

HC-DFS1489 01-21

### Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical

Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS1490 01-21

**Participation Date**

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which your Fund becomes a participant in the plan of insurance authorized by the agreement of Trust.

HC-DFS18 04-10
V1 M

**Participating Provider**

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

HC-DFS1194 01-19

**Patient Protection and Affordable Care Act of 2010 ("PPACA")**

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

HC-DFS412 01-11

**Pharmacy**

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

HC-DFS851 10-16

**Pharmacy & Therapeutics (P&T) Committee**

A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

HC-DFS1495 07-20

**Physician**

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10
V1

**Prescription Drug Charge**

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), the plan sponsor is obligated to pay for a covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax.

HC-DFS1320 01-19
V1

**Prescription Drug List**

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by your Fund as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of

the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFS1775 01-23

**Prescription Drug Product**

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified in the Prescription Drug List:

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy; and
- Certain digital products, applications, electronic devices, software and cloud based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

HC-DFS1633 01-22

**Prescription Order or Refill**

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

HC-DFS856 10-16

**PPACA Preventive Medication**

The Prescription Drug Products or other medications (including over-the-counter medications) designated as payable by the plan at 100% of the cost (without application of any Deductible, Copayment or Coinsurance) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A written prescription is required to process a claim for a PPACA Preventive Medication. You may determine whether a drug is a PPACA Preventive Medication through the internet website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS1513 10-20

**Preventive Treatment**

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10
V1

**Primary Care Physician**

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been voluntarily selected by you and is contracted as a Primary Care Physician with, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

**Psychologist**

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

**Review Organization**

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

HC-DFS808 12-15

**Room and Board**

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS1481 01-21

**Sickness – For Medical Insurance**

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50 04-10
V1

**Skilled Nursing Facility**

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

**Specialist**

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10
V1

**Specialty Prescription Drug Product**

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS858 10-16

**Stabilize**

Stabilize means, with respect to an Emergency Medical Condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

HC-DFS1768 01-23

**Terminal Illness**

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54 04-10
V1

**Therapeutic Alternative**

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS859 10-16

**Therapeutic Equivalent**

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS860 10-16

**Urgent Care**

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

HC-DFS34 04-10
V1

**Usual and Customary (U&C) Charge**

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

HC-DFS861 10-16