Plan Document/ Summary Plan Description

IBEW/Western Utilities Health and Welfare Trust Fund

Amended, Restated, and Effective January 1, 2018

Discussing the:

- Medical Plan
- Dental Plan
- Vision Plan
- Life Insurance Plan

IBEW/Western Utilities Health & Welfare Trust Fund

PacifiCorp

TABLE OF CONTENTS

1. INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This handbook is both the Plan Document and Summary Plan Description (SPD) and describes the Rules and Regulations for the medical plan options, including the Premium Health Plan, the Premium Plus Plan, the Comprehensive Health Plan and the Consumer Driven Health Plan (CDHP) that is combined with a Health Savings Account, the insured HMO Plan (however, it is described in a separate document) as well as the Dental plan and Vision plan benefits of the IBEW/Western Utilities Health and Welfare Trust Fund, hereafter referred to as the Fund. This document also outlines the insured Life Insurance and Accidental Death and Dismemberment (AD&D) benefits available to you.

The Plan described in this document is effective January 1, 2018 and replaces all other Plan Document/Summary Plan Descriptions previously provided to you. We know how important the Fund's benefits are to your financial security. Protecting you and your family against catastrophic medical bills has always been, and will remain, our Fund's number one goal.

This document 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 Fund. 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 Fund. Be sure to read the Exclusions and Definitions chapters.

- **Remember, not every expense you incur for health care is covered by the Fund.**
- **Note that your eligibility or right to benefits under this should not be interpreted as a guarantee of employment.**

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. There is a Quick Reference Chart in this chapter that contains the name, address and phone numbers of various firms that can help you understand your benefits.

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

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

These medical plan options include outpatient prescription drug benefits: Premium Health Plan, Premium Plus Plan, Comprehensive Health Plan and Consumer Driven Health Plan (CDHP) that is combined with a Health Savings Account and, along with the Dental Plan and Vision Plan benefits, are self-funded with contributions from participating Employers held in a Trust Fund. Independent claims administrators pay benefits out of Fund assets.

Individuals (union employees) associated with Local 125 residing in portions of Washington State and Oregon are also being offered an HMO plan option in addition to the benefits in this document. HMO benefits are **not** described in this document and instead are described in a separate document available from the Claims Administrator (whose name and address are listed on the Quick Reference Chart in this document). If the insured HMO medical plan option is elected, the Dental, Vision and Life and AD&D benefits outlined in this document also apply to (and are able to be elected by) individuals (union employees) associated with Local 125 who reside in the HMO service area.

The Life and AD&D Insurance benefits described in this document are fully insured with an insurance company whose name is listed on the Quick Reference Chart in the Introduction chapter of this document. This document provides an outline of the Life and AD&D Insurance benefits that have been provided to you in a Certificate of Coverage by the Insurance Company.

SPANISH LANGUAGE ASSISTANCE

Pongase en contacto con la oficina de administracion si no entiende los beneficios del Plan al numero 1-855-617-2478. This Plan Document/Summary Plan Description contains a summary in English of your Plan rights and benefits.

If you have difficulty understanding any part of this document please contact the Administrative Office at their address and phone number listed on the Quick Reference Chart in this document.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the PacifiCorp's Employee Benefits Department information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth and change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan preferably within 31 days, but for certain events like divorce or a child reaching the limiting age for coverage, no later than 60 days, after any of the above noted events.

Failure to give the PacifiCorp's Employee Benefits Department **a timely notice of the above noted events may:**

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

If you have any **questions regarding eligibility**, please contact PacifiCorp's Employee Benefits Department. If you have **questions or need help filing a claim** please contact the Claims Administrator and the other firms listed on the Quick Reference Chart in the next chapter.

NO VESTED RIGHTS

No Participant, Employee, Employer, or any other person shall have any vested right to any benefit(s) provided by the Fund.

NO GUARANTEE

None of the medical benefits provided under the Fund are guaranteed by the Board of Trustees, PacifiCorp Power, Rocky Mountain Power, the Union or any other individual entity. The benefits may be provided only from assets in the Fund collected and available for such purposes. The Board of Trustees reserves the right in its sole discretion and without notice to Participants, Employees, Dependents, Employers, the Union and others affected, to interpret, amend, terminate, modify all or part of this Plan and take any action they deem desirable to preserve the financial stability of the Fund.

NO AGENT MAY INTERPRET

The Employer, Union representatives, and individual Trustees are not authorized to furnish any information regarding the Fund's benefits or eligibility requirements. Only the Board of Trustees can make these interpretations. Any questions regarding eligibility or benefits should be sent to the Board of Trustees in care of the Claims Administrator.

SUGGESTIONS FOR USING THIS DOCUMENT

You have a choice between several health plan options: the Premium Health Plan, the Premium Plus Plan, the Comprehensive Health Plan and the Consumer Driven Health Plan (CDHP) that is combined with a Health Savings Account (HSA). These plan options are described more fully in the Schedule of Medical Benefits chapter in this handbook.

No one expects you to know the "ins and outs" of the health care system. Our goal is to make sure you get the information you need to make decisions about your health care treatment. This document provides extensive information about your Plan. We think you will find the following chapters particularly useful:

- **Read through this Introduction and look at the Table of Contents that immediately precedes it.** If you don't understand a term, look it up in the Definitions chapter. The **Table of Contents** provides you with an outline of the chapters. The **Definitions** chapter explains many technical, medical and legal terms that appear in the text.
- This document contains a **Quick Reference Chart** following this introductory text. This is a handy resource for the names, addresses and phone numbers for the key contacts for your benefits such as the Claims Administrator or PPO network.
- **Review the Medical Plan Options chapter, Schedule of Medical Benefits and Medical Exclusions chapters.** These describe your benefits in more detail. There are examples, charts and tables to help clarify key provisions and more technical details of the coverages.

- **Review the Dental Expense, Schedule of Dental Benefits and Dental Exclusions** chapters for an explanation of the dental benefits of this Plan.
- **Review the Vision Plan with the Schedule of Vision Benefits and Vision Exclusions** chapters for an explanation of the vision benefits of this Plan.
- **Refer to the General Provisions chapter** for information regarding your rights and information about ERISA. **Refer to the Claim Filing and Appeals Information chapter** to find out what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claims decision.
- **The chapter on Coordination of Benefits** discusses situations where you have coverage under more than one group health care plan, Medicare, another government plan, personal injury protection under mandatory no-fault automobile insurance coverage, workers' compensation, or where you can recover expenses from a third party who wrongfully caused the injury or illness giving rise to those expenses.
- **The COBRA chapter** discusses your options if coverage ends for you or a covered Spouse or Dependent Child.
- **Refer to the Life and AD&D chapter** for an overview on Employee and Dependent life insurance and employee benefits for Accidental Death and Dismemberment (AD&D) insurance.

Sincerely,

The Board of Trustees for the IBEW/Western Utilities Health and Welfare Trust Fund

2. QUICK REFERENCE CHART

WHOM TO CALL 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:

Information Needed	Contact
CLAIMS ADMINISTRATOR (Administrative Office) • Claims Administration for the Premium Health Plan, Premium Plus Plan, Comprehensive Health Plan, and Consumer Driven Health Plan (CDHP) that is combined with a Health Savings Account (*See the Behavioral Health Program row for information on claims administration for behavioral health claims*) • Claims Administration for the Vision Plan • Claim Status Inquiries and Claim Forms • Appeal of Medical, Behavioral Health and Vision Claims • Eligibility for Coverage and Plan Benefit Information • COBRA Administration: Premium Payment, Cost of COBRA Coverage, Adding or Dropping Dependents from COBRA • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC) • FSA Administration	**BeneSys, Inc.** P. O. Box 215 San Ramon, CA 94583 **Toll-free Phone: 1-855-617-2478** Fax: 925-297-6655 www.ibew-west.com
COBRA ADMINISTRATOR	**BeneSys, Inc**. (as noted above)
PPO NETWORKS (Medical) • Medical Network Provider Directory (at no charge)	**For all areas except Utah and Wyoming:** **CIGNA** Toll-Free: 1-800-768-4695 www.cignasharedadministration.com **For Utah and Wyoming:** **Wise Provider Networks (Imagine Health Networks)** Toll-Free: 1-866-485-5205 Phone: 801-566-6655 www.wiseprovidernetworks.com
UTILIZATION MANAGEMENT (UM) PROGRAM • Precertification of medical and surgical services • Case Management • Appeal of Utilization Management recommendations	**For Utah and Wyoming:** **American Health Group (AHG)** Phone number: Toll-Free: 1-800-847-7605 **For all areas except Utah and Wyoming:** **CIGNA** Phone number: Toll-Free: 1-800-768-4695
HEALTH SAVINGS ACCOUNT (HSA) ADMINISTRATOR	**Health Equity** **Customer Service: 866-346-5800** www.myhealthequity.com

Information Needed	Contact
VIDEO VISIT • The Fund has contracted with ***Doctor On Demand***, offering on-demand video visits for all participants and their eligible family members. Participants can speak via live video with ***Doctor on Demand's*** US-licensed physicians, psychologists, and psychiatrists. • To use the service, download the ***Doctor On Demand*** app. The app works with any smartphone, tablet, or computer with a front-facing camera. • You can download the app, sign up and connect to a US-licensed provider for a medical visit via live video. The typical average wait time to see a board-certified physician is under 5 minutes. • ***Doctor On Demand*** doctors can treat a wide variety of conditions, including 90% of the conditions most commonly seen in the ER. • **Cost:** Your cost will be the same as your PCP Copay on the plan you are currently enrolled in. The Fund is paying the rest of the cost of the video visit. In comparison, Urgent Care visits average $180; ER visits $700. If you have questions, you can call Member Support toll free at **1-800-997-6196**.	**Doctor on Demand** Available 24/7/365 Phone: 1-800-997-6169 Email: support@doctorondemand.com Website: http://www.doctorondemand.com/ Mobile App is available to download from the Apple App Store and Google Play or from http://www.doctorondemand.com/.
PRICE FINDER: Finding the Price of Certain Health Care Services • The Fund partners with Healthcare Bluebook, a **free online mobile tool** that provides pricing information for hundreds of health care services, including services from network providers. You can shop for the most affordable care in your area. • With the "Go Green to Get Green" program, when you select a "green" service, Healthcare Bluebook will send you a reward ranging from $25 to $100 based on the procedure.	**Healthcare Bluebook** For more information log onto Healthcare Bluebook at www.healthcarebluebook.com/cc/IBEWWesternUtilities using your last name and your date of birth.
PRESCRIPTION DRUG PROGRAM • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Service • Prescription Drug Information • Direct Member Reimbursement (DMR) for out-of-network prescription drug claims and appeals • Precertification/preapproval of certain drugs • Step Therapy of Certain Drugs • Specialty Drug Program: Precertification and Ordering • List of generic Maintenance drugs payable at Mail Order with no cost-sharing • List of Preventive medications payable by the Plan	**Sav-Rx** • **Customer Service for Retail and Mail Order:** 1-866-233-4239 • **Specialty Drug and Step Therapy Program:** 1-866-233-IBEW (4239) • **Mail Order Address:** Sav-Rx Prescription Services P. O. Box 8 Fremont, NE 68026-0008 www.savrx.com (information and claim forms) • **Direct Member Claim Reimbursement:** Mail your prescription drug claim from an out-of-network retail pharmacy to: 224 N. Park Avenue Fremont, NE 68025-0008

Information Needed	Contact
EMPLOYEE ASSISTANCE PROGRAM (EAP) • EAP counseling & referral services for mental health, stress, substance abuse, work life services and many more topics outlined below. The EAP is available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home. Services are confidential and available 24 hours a day, 7 days a week. • The **EAP program provides up to eight (8) counseling sessions** with an EAP Network Provider or televideo provider, delivered via face-to-face, telephonically, or televideo per problem per contract year. • You can call the EAP 24 hours a day for in-the-moment **emotional well-being support**. You can visit with a counselor face to face, online with televideo or get in-the-moment support by phone. Services are free and confidential. The EAP can help with a wide range of issues including: •Relationship support •Stress management •Work/life balance •Family issues •Grief and loss •Depression •Anxiety •Substance misuse and more •Self-esteem and personal development • **Daily life assistance**: Competing day-to-day needs can make it tough to know where to start. Call for personalized guidance and the EAP will find resources for: •Child care, parenting and adoption •Summer programs for kids •School and financial aid research •Care for older adults •Caregiver support •Special needs •Pet care •Home repair and improvement •Household services and more. • **Online resources:** the EAP offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find: •Articles and self-assessments •Adult care and child care provider search tool •Stress resource center •Video resources •Live and recorded webinars •Mobile app •Discount Center and Fitness (gym) discounts. • **Identity theft services**: One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims. • **Legal services**: You can get a free 30-minute consultation with a participating attorney for each new legal topic related to: •General/Family/Criminal law •Elder law and estate planning •Divorce •Wills and other document preparation •Real estate transactions •Mediation services. If you opt for services beyond the initial consultation you can get a 25% discount. Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services. • **Financial services**: Simply call the EAP for a free 30-minute consultation for each new financial topic related to: •Budgeting •Retirement or other financial planning •Mortgages and refinancing •Credit and debt issues •College funding •Tax and IRS questions and preparation. You can also get a 25% discount on tax preparation services. Services must be for financial matters related to the employee and eligible household members.	**Resources For Living** 1-800-563-1046 (Select Option 2) www.resourcesforliving.com www.mylifevalues.com See also www.myeap.com (New User: register with login ID in all caps "IBEWWESTERNUTILITIES"). Password: EAP.

Information Needed	Contact
BEHAVIORAL HEALTH PROGRAM (Mental Health and Substance Abuse Treatment) • Inpatient and Outpatient Behavioral Health Services • Precertification of Behavioral Health Services • Appeal of Behavioral Health recommendations • Behavioral Health Provider Directory (at no charge) • (Kaiser HMO participants have behavioral health care through Kaiser Permanente)	**Aetna Behavioral Health** 1-800-563-1046 (Select Option 1)
DENTAL PLAN • In-Network Dental Providers and Network Directory (at no charge) • Claims for Dental Services • Appeal of Dental Claims	**Delta Dental** P. O. Box 1809 Alpharetta, GA 30023-1809 Customer Service: 1-800-521-2651 www.deltadentalins.com
HMO MEDICAL PLAN OPTION • (HMO medical plan benefits for residents of Washington and Oregon are not described in this booklet and instead are available by contacting the HMO or, the Claims Administrator in the first row of this chart)	**Kaiser Permanente** Membership Services: • For Portland: 503-813-2000 • All other areas: 1-800-813-2000 www.kaiserpermanente.org
LIFE INSURANCE • Employee Basic Life Insurance, Accidental Death and Dismemberment (AD&D), Voluntary Supplemental Life Insurance, Dependent Life Insurance	**Life Insurance Company of North America, a CIGNA Company** To file a claim for benefits for life insurance benefits contact the Administrative Office at their phone number in the first row of this chart.
PLAN ADMINISTRATOR (Board of Trustees) • Trust Office	**Board of Trustees for the IBEW/Western Utilities Health and Welfare Trust Fund** 1-855-617-2478 *Mail Correspondence to:* Plan Administrator for IBEW/Western Utilities Health and Welfare Trust Fund c/o BeneSys, Inc. P. O. Box 215 San Ramon, CA 94583 www.ibew-west.com
ELIGIBILITY AND ENROLLMENT • Address changes • Mid-year change in status • Online enrollment	**PacifiCorp Employee Benefits Department** 825 N. E. Multnomah, Suite 1800 LCT Portland, OR 97232 1-800-455-6363 www.pacificorp.com benefits.services@pacificorp.com
HIPAA PRIVACY OFFICER • HIPAA Notice of Privacy Practice	**Privacy Officer for the IBEW/Western Utilities Health and Welfare Trust Fund** c/o BeneSys, Inc. P. O. Box 215 San Ramon, CA 94583 Toll-free Phone: 1-855-617-2478
HIPAA SECURITY OFFICER	**Security Officer for the IBEW/Western Utilities Health and Welfare Trust Fund** c/o BeneSys, Inc. P. O. Box 215 San Ramon, CA 94583 Toll-free Phone: 1-855-617-2478
LOCAL UNIONS	**Local 57** 4551 S. Atherton Drive Salt Lake City, UT 84123 Phone: 801-270-5757 **Local 125** 17200 N.E. Sacramento Portland, OR 97230 Phone: 503-262-9125

3. ELIGIBILITY—

How and When Coverage Begins, is Maintained, and Ends

WHO IS ELIGIBLE FOR COVERAGE/START OF COVERAGE

Active Employee Eligibility:

You are eligible to participate in this Fund if you are an active Employee of an Employer who participates in the Fund. Active Employees include:

- All regular full-time bargaining unit Employees who are scheduled to average 30 hours of service or more per week.
- All regular part-time bargaining unit Employees who are scheduled to average 20 hours of service or more per week but less than 30 hours of service per week.

Hour(s) of Service: means, as determined by the contributing employer:

a. each hour for which an employee is paid, or entitled to payment, for the performance of duties for an employer; and

b. each hour for which an employee is paid, or entitled to payment by an employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

An hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or (according to the final Shared Responsibility regulations) to the extent the compensation for services performed constitutes "income from sources without the United States".

Each contributing employer, who is an applicable large employer, reserves the right to use a Monthly Measurement Method and/or a Look Back Measurement Method to determine if an employee reaches the level of a full-time employee, in accordance with IRS regulations under the Affordable Care Act.

a. The Monthly Measurement Method identifies full-time employees based on the hours of service achieved for each calendar month.

b. The Look-Back Measurement Method determines the status of a new employee or an ongoing employee as full-time or not for a future period (called a stability period) based on the average number of hours of service per week the employee attained in a prior period (called a measurement period).

c. The specific duration of periods under the Look Back Measurement Method (when used) are addressed in policies/procedures of the contributing employer.

For New Employees who elect benefits: medical, dental, vision and life insurance, coverage will become effective as of the first day of the month after or coinciding with your date of employment, but only if you have submitted a completed online enrollment, within 31 days of your date of employment.

Former Employee Eligibility:

You are also eligible to participate in this Fund if you are a former Employee receiving periodic disability payments under the Long Term Disability insurance program sponsored by the Employer, provided you were previously classified as an Active Employee eligible to participate in this Fund before becoming disabled. Long Term Disability insurance benefits are not provided by the Trust Fund nor described in this document.

Your Dependents' Eligibility:

Eligible Dependents are able to elect the same medical, dental and/or vision coverage as the Employee on the later of the day the Employee becomes eligible for medical coverage or the day the Employee acquires an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have submitted a completed online enrollment and if that medical coverage is in effect for you on that day and you pay any required contribution for coverage of the Dependent(s). A Dependent may not be enrolled for coverage unless, the Employee is also enrolled. Specific documentation to substantiate Dependent status may be required (see "Proof of Dependent Status" below).

Your Eligible Dependents include your lawful Spouse and your Dependent Child(ren) as those terms are defined in the Definitions chapter of this document. Anyone who does not qualify as a Dependent Child or Spouse as those terms are defined by the Fund has no right to any coverage for benefits or services under this Plan.

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate Dependent status will be required and may include any of the following:

- **Marriage:** Certified copy of marriage certificate.
- **Birth:** Certified copy of the birth certificate.
- **Stepchild:** Certified birth certificate plus marriage certificate.
- **Adoption or placement for adoption:** Court order paper signed by the judge.
- **Involuntary loss of Dependent coverage:** Certificate of coverage from previous employer and marriage certificate if not already on file.
- **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate.
- **Foster child**: court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction, plus the child's birth certificate.
- **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically Disabled (as that term is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and that the child meets the Fund's definition of Dependent Child as noted in the Definitions chapter of this document.
- **A Qualified Medical Child Support Order (QMCSO)**. Refer to the explanation below for additional details.

ENROLLMENT PROCEDURES

There are four opportunities to enroll for coverage under this Plan. The three pre-tax enrollment opportunities are: Initial Enrollment, Special Enrollment, and Open Enrollment. The fourth enrollment opportunity is called the Special Post Tax Enrollment. These opportunities are described further in this chapter.

Procedure to Request Enrollment:

Generally, an individual must request to enroll in the Fund by completing the online enrollment process. Contact the PacifiCorp Employee Benefits Department for assistance with online enrollment. The contact information for the PacifiCorp Employee Benefits Department is listed on the Quick Reference Chart in the front of this document.

Note that the Open Enrollment procedure can differ from this process and if so, the procedure on how to enroll at this time will be announced by the Fund at the beginning of the Open Enrollment period.

Once enrollment is requested, you will be provided with the steps to enroll that include all of the following:

a. Submit a completed online enrollment, and

b. Provide proof of Dependent status (as requested), and

c. Pay any required contributions for coverage, and

d. Perform steps a through c above in a timely manner according to the timeframes noted under the Initial, Special, or Open enrollment provisions of this Plan.

Proper enrollment is required for coverage under this Plan.

Enrollment Is Required for Coverage:

You and/or your Eligible Dependents may become covered under this Plan only upon submission of a completed online enrollment. If you fail to enroll when you are first eligible for coverage you will be defaulted into the Consumer Driven Health Plan option for Employee coverage only, at no cost to you. Certain default provisions that apply during an Open Enrollment period are announced in the applicable Open Enrollment Guide.

No Employee may decline (opt-out of) medical coverage under this Plan, except an employee hired through the Union's hiring hall, casual, temporary or a leased employee.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

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

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

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

COVERAGE FOR SURVIVING SPOUSE AND CHILDREN

Effective January 1, 2004, Dependents of an Employee who dies as a result of a work-related accidental injury may continue their coverage under this Plan after the death of the Employee, if the Dependents are otherwise eligible to enroll, until the end of the month in which the Employee would have turned age 55. A surviving Spouse or Dependent Child not currently eligible to enroll in the Plan at the time of the Employee's work-related death (notwithstanding a child resulting from a pregnancy in process at the time of the Employee's death) may **not** enroll in this Plan after the Employee's death.

For the first three years after the death of the Employee, the eligible Dependent's coverage will be paid entirely by the Employee's former employer; thereafter the former employer will pay the Employer portion and the Dependent(s) will pay the Employee portion of the contribution requirement. This coverage extension will be offered coincidental with the offering of COBRA coverage, as it covers the 36-month period of extension provided by COBRA. Additional rights provided by COBRA continue to be available at the program's COBRA contribution requirements. COBRA is not available in addition to this extension.

At such time as the deceased Employee would have reached age 55, the Dependents will lose eligibility under this Plan and become eligible for the Retiree Medical Program of the former employer (if applicable).

An Accident while traveling to or from work (consistent with the coverage and determination under the Company's Business Travel Accident Policy) a copy of which can be obtained from PacifiCorp's Employee Benefits Department at the telephone number and address listed in the Quick Reference Chart and not eligible per the terms above may continue their coverage under this Plan after the death of the Employee, if the Dependents are otherwise eligible to enroll, until the earlier of:

- End of month in which the Employee would have turned age 55, or
- The end of the month following the three-year anniversary of the Employee's death.

1. A surviving Spouse or Dependent Child not currently eligible to enroll in the Plan at the time of the Employee's death (notwithstanding a child resulting from a pregnancy in process at the time of the Employee's death) may **not** enroll in this Plan after the Employee's death.
2. For the first year after the death of the Employee, the Dependent's coverage will be paid entirely by the Employee's former employer. For the remaining two years the coverage will be paid for by the Fund.
3. At such time as the deceased Employee would have reached age 55, the Dependents will lose eligibility under this Plan.
4. This coverage extension will be offered coincidental with the offering of COBRA coverage, as it covers the 36 month period of extension provided by COBRA. Additional rights provided by COBRA continue to be available at the program's COBRA contribution requirements. COBRA is not available in addition to this extension.

INITIAL ENROLLMENT

In order to have benefits pre-taxed, you must enroll no later than 31 days after the date on which you are eligible for coverage by submitting a completed online enrollment. If you want Dependent coverage, you must enroll your Eligible Dependents at the same time.

Start of Coverage Following Initial Enrollment: Your coverage begins on the first day of the month on or following the date your employment begins, provided you properly enroll as described in the paragraph above. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins.

SPECIAL ENROLLMENT

There are three HIPAA Special enrollment opportunities to enroll in the Plan's benefits mid-year: a) upon gaining (acquiring) a new dependent, b) loss of other coverage, and c) on account of Medicaid or a State Children's Health Insurance Program (CHIP). These opportunities are explained below:

A. Newly Acquired Spouse and/or Dependent Child(ren)

- **If you are enrolled for coverage** and if you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption or marriage, you may request enrollment for your newly acquired Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption, or placement for adoption. Information about the online enrollment process can be obtained from the PacifiCorp Employee Benefits Department.
- **If you did not enroll your Spouse for coverage within 31 days of the date on which he or she became eligible for coverage,** and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption or marriage, you may request enrollment for your Spouse and/or your newly acquired Dependent Child and/or any Dependent Child(ren) no later than 31 days after the date of your newly acquired Dependent Child's birth, adoption or placement for adoption.
- To request Special Enrollment see the steps described under "Enrollment Procedure" discussed earlier in this chapter.

To obtain more information about Special Enrollment, contact the Administrative Office.

B. Loss Of Other Coverage

If, you do not request enrollment under this Plan for yourself, your Spouse and/or any Dependent Child(ren) within 31 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation Coverage, individual insurance, Medicare, or other public program; **and** your Spouse and/or any Dependent Child(ren) cease to be covered by that other health insurance policy or plan; you may request enrollment for that Spouse and/or any Dependent Child(ren) within 31 days after the termination of their coverage under that other health insurance policy or plan **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- The health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceases to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered; or
- the loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the **failure of the individual** to pay the applicable COBRA premium on a timely basis, or **for cause** (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- Due to the employer's or other responsible party's failure to remit premiums on a timely basis; or
- When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual; or
- Because the 18-month, 29-month, or 36-month (as applicable) period of COBRA Continuation Coverage has expired; or
- When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual.

However, you may not avail yourself of this opportunity for Special Enrollment for your Dependent(s) unless, when coverage under this Plan was previously offered (at the time of Initial or Special Enrollment), you indicated in writing that the reason your Spouse and/or your Dependent Child(ren) declined coverage was because they had coverage under another health insurance policy or plan.

C. Medicaid or a State Children's Health Insurance Program (CHIP):

Benefits-eligible employees and their eligible dependents may also enroll in this Plan if the employee (or their eligible dependents):

a. have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or

b. become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

- **Coverage of an individual enrolling due to loss of other coverage or because of marriage**, if the individual requests Special Enrollment within 31 days of the date of the event that created the Special Enrollment opportunity or on account of Medicaid or a State Children's Health Insurance Program (CHIP), your coverage, your Spouse's coverage, and/or the coverage of any of your other Dependent Child(ren) will become effective on the first day of the month following the date the Fund receives the completed online enrollment.
- If the individual requests Special Enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP)**, generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
- **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 31 days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child** who is enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.
- **Failure to Enroll During Special Enrollment (Very Important Information):** If you fail to enroll any of your Eligible Dependents within 31 days (or as applicable 60 days) after the date on which they first become eligible for Special Enrollment, you will not be able to enroll them (under the pre-tax provisions of the Plan) until the next Open Enrollment period.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly-situated Employees at Initial Enrollment.

Special Post-Tax Enrollment:

Alternatively, if you fail to enroll any of your Eligible Dependents within the time periods stated for Special Enrollment, you may utilize the **Special Post-tax Enrollment** (referred to above under Enrollment Procedures), which would require you to pay any applicable contribution for such Dependent coverage on an after-tax basis until the next effective date for coverage following an Open Enrollment in which you have made an affirmative election to include such Dependents(s).

OPEN ENROLLMENT

Open Enrollment Period: Open Enrollment is the period of time during the fall of each year to be designated by the Fund Administrator during which eligible Employees may make the elections specified below.

Elections Available During Open Enrollment: During the Open Enrollment period, you may elect, for yourself and your Eligible Dependents who are eligible for coverage, to:

- **Enroll** in one of the health plans options offered by the Fund; or
- **Add or drop** Eligible Dependents to the coverage; or
- **Change** health plan options.

Restrictions on Elections During Open Enrollment: No Dependent may be covered unless you are covered. You and all your covered Eligible Dependents must be enrolled for the same health plan option. All relevant parts of the online enrollment must be completed before the end of the Open Enrollment period.

Start of or Changes to Coverage Following Open Enrollment: If you or your Spouse or Dependent Child(ren) are **enrolled for the first time** during an Open Enrollment period, that person's coverage will begin on the first day of the Calendar Year

following the Open Enrollment. If you or your Spouse or Dependent Children are **changing coverage** during Open Enrollment, such changes will become effective on the first day of the Calendar Year following Open Enrollment.

Failure to Make a New Election During Open Enrollment: If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, you will be considered to have made an election to retain the same health care coverages you had during the preceding Plan Year (unless the Open Enrollment materials provide other instructions). However, you will not have any part of your pay allocated to the Fund's Flexible Spending Account for a Plan Year unless you affirmatively elect to do so for that Plan Year, even if you had elected Flexible Spending Account coverage for the previous year.

Failure to Enroll During Open Enrollment (Very Important Information):

- If you fail to enroll any of your Eligible Dependents within 31 days after the date on which you or they become eligible for Open Enrollment, unless your Eligible Dependents qualify for the Special Enrollment described in the previous section of this chapter, you will not be able to enroll them (using the pre-tax or post-tax provisions of the Plan) until the next Open Enrollment period.
- If, during the Open Enrollment period, an Active Employee does not enroll in the Premium Health Plan, Premium Plus Plan or the Comprehensive Health Plan, **the Active Employee will automatically be enrolled into the Consumer Driven Health Plan**.

LATE ENROLLMENT

This Plan does not maintain a late enrollment period. If you failed to enroll your Dependent(s) when you first became eligible for coverage you may only enroll those Dependents at the annual Open Enrollment period, unless they qualify for a Special Enrollment opportunity as described in this chapter. However, see the special rules for coverage of newborn and adopted Dependent Children in this chapter.

NEWBORN DEPENDENT CHILDREN (Special Rule For Coverage)

Your newborn Dependent Child(ren) **will automatically be covered for the first 31 days measured from the date of birth, only <u>if either parent is covered under this Plan</u> at the time of the child's birth**.

- **If neither the mother or father is covered under this Plan at the time of the child's birth**, the plan can accept a Special Enrollment of an eligible child with coverage for the newborn back to the date of birth **only if** enrollment is requested for that newborn Dependent Child within 31 days after the child's date of birth by submitting a completed online enrollment and paying any required contribution for that Dependent Child's coverage.
- A newborn Dependent Child(ren) will continue to have coverage **after the initial 31-day period <u>only if</u> you request enrollment** for that newborn Dependent Child within 31 days after the child's date of birth by submitting a completed online enrollment and paying any required contribution for that Dependent Child's coverage.

Remember that you may not enroll a newborn Dependent Child for coverage unless you, the Employee, are also enrolled for coverage. See also the Special Enrollment provisions in this chapter.

ADOPTED DEPENDENT CHILDREN (Special Rule For Coverage)

Your adopted Dependent Child **will be covered for 31 days from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, as stated under the rules below**. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

- **A <u>newborn</u> child who is Placed for Adoption with you <u>within 31 days after the child was born</u>** will automatically be covered from the date of birth only if at least one of the parents who is adopting the child, is covered under the Plan at the time of the newborn child's birth. Note that the Fund does not cover the birth mother's delivery expenses.
- **If the parent who is adopting the child is not covered under this Plan at the time of the child's birth**, the adopted newborn can be added to the Plan with coverage for the newborn who is Placed for Adoption effective back to the date of birth **only if** enrollment is requested for that child within 31 days after the child's date of birth, by submitting a completed online enrollment and paying any required contribution for that child's coverage.
- Your newborn child who is Placed for Adoption **can continue to have coverage after the initial 31-day period only if you request enrollment** for that child within 31 days after the child's date of birth by submitting a completed online enrollment and paying any required contribution for that child's coverage.
- **A Dependent Child <u>adopted more than 31 days</u> after the child's date of birth** will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, only if you submit a completed online enrollment and provide proof of Dependent status (if requested) and pay any required contribution for that Dependent Child's coverage, within 31 days of the child's adoption or placement for adoption.

If the adopted Dependent Child is not properly enrolled in a timely manner, you must wait until the next Open Enrollment period or Special Enrollment period under the pre-tax provisions of this Plan. If a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the Employee, are also enrolled for coverage. See also the Special Enrollment provisions in this chapter.

PRE-EXISTING CONDITIONS

Effective January 1, 2014, the Plan will not exclude or limit coverage of an item or service based solely on the fact that the condition constituted a Pre-Existing Condition.

WHEN YOU AND ANY OF YOUR DEPENDENTS ARE BOTH COVERED UNDER THE FUND (Special Rule For Enrollment)

If both parents are covered under the Fund as Active Employees, each will be eligible both as an Active Employee and as a Dependent. If a Participant has such dual coverage the total amount of benefits payable under the Fund shall in no event exceed the amount of expense actually incurred for which benefits are payable under the Fund.

If both parents of an eligible Dependent Child are Active Employees, such child will be eligible as a Dependent of **each** Active Employee. If a Participant has such dual coverage, the total amount of benefits payable under the Fund will in no event exceed the amount of expense actually incurred for which benefits are provided under the Fund.

If, while your family coverage is in effect, any of your Dependent Children becomes an Employee of the Fund and becomes eligible for coverage as an Employee:

- That child will cease to be a Dependent Child, and may enroll for coverage as an Employee, in which case coverage as a Dependent Child will terminate as of the date coverage as an Employee begins.
- If the Employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent Child, the Employee-child will immediately be deemed to be covered as a Dependent Child of the Employee-parent. As a result, the Employee-child will not sustain a loss of coverage because of termination of employment or reduction in hours. Contributions for Dependent coverage will be deducted from the pay of the Employee-parent, and, if applicable, will be adjusted as may be required when a Dependent Child becomes an Employee and ceases to have coverage as a Dependent Child, or when the Employee-child ceased to be an Employee and resumes coverage as a Dependent Child.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) (Special Rule for Enrollment)

1. This Plan will provide benefits in accordance with a National Medical Support Notice. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Fund recognize the child as a Dependent even though the child may not meet the Fund's definition of Dependent. A QMCSO usually results from a divorce or legal separation and typically:
    - Designates one parent to pay for a child's health plan coverage;
    - Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
    - Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined;
    - States the period for which the QMCSO applies; and
    - Identifies each health care plan to which the QMCSO applies.
2. An order is not a QMCSO if it requires the Fund to provide any type or form of benefit or any option that the Fund does not otherwise provide, or if it requires an Employee who is not covered by the Fund to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
3. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the Employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the Employee is covered by the Fund, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

4. If the Employee is a Plan Participant, the QMCSO may require the Fund to provide coverage for the Employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan Participant. The Fund will accept a Special Enrollment of the Dependent Child(ren) specified by the QMCSO from either the Employee or the custodial parent. Coverage of the Dependent Child(ren) will become effective as of the date the enrollment is received by the Fund, and will be subject to all terms and provisions of the Plan, limits on selection of provider and requirements for authorization of services, as permitted by applicable law.
5. No coverage will be provided for any Dependent Child under a QMCSO unless the applicable Employee contributions for that Dependent Child's coverage are paid, and all of the Fund's requirements for coverage of that Dependent Child have been satisfied. Contributions required for coverage under a QMCSO are the total Employer contributions required for coverage of the Employee and all members of the Employee's family who are enrolled in the Fund, plus the contributions otherwise actually being paid by the Employee, if applicable.
6. Coverage of a Dependent Child under a QMCSO will terminate when coverage of the Employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA Coverage, if that right applies. For additional information (at no charge) regarding the procedures for payment of claims under QMCSOs, see the Claim Filing and Appeals Information chapter of this document or contact the Administrative Office.

PAYMENT FOR YOUR COVERAGE

PacifiCorp d.b.a. Pacific Power and Rocky Mountain Power makes contributions to the Fund (calculated at a fixed predetermined amount) that pay the full cost of Employee and Dependent coverage in the Consumer Driven Health Plan option. If you choose the Premium Health Plan, the Premium Plus Plan or the Comprehensive Health Plan options, your Employer pays the majority of the cost of your Employee coverage and your Dependents coverage. The amount that you and the other Employees pay for the Premium Health Plan, the Premium Plus Plan or the Comprehensive Health Plan option is based on the cost of the Fund for all of the people that it covers.

The specific amount you must pay for medical coverage is announced annually during Open Enrollment. Contributions for subsequent years will be announced each year during the Open Enrollment period. Participants make the full contribution for COBRA coverage, if elected.

For three of the enrollment opportunities under this Fund, Initial Enrollment, Special Enrollment and Open Enrollment, you pay your contributions for the medical, dental and vision coverages and your contribution to the Flexible Spending Accounts on a **before-tax** basis. This means that your **payments** for these coverages come from your pay before federal taxes are withheld. That way, you should pay less in taxes. However, before-tax contributions do not lower your pay-related benefits such as pension, life insurance and long-term disability. The before-tax contributions you make toward your coverage may lower the annual pay used to determine your Social Security benefits if you retire or are disabled. However, because Social Security benefits are calculated on your annual income over the course of your career, with limits and adjustments made according to complex formulas, the effect (if any) of before-tax contributions is likely to be minimal.

CHANGING YOUR COVERAGE DURING THE YEAR (Mid-Year Change of Status)

Government regulations generally require that your Plan coverages remain in effect throughout the Plan Year (from January 1 through December 31), but you may be able to make some changes during the year (mid-year) if the Plan Administrator or its designee determines that you have a qualifying change in your status affecting your benefit needs. The following qualifying changes are the only ones permitted under the Plan:

1. **Change in legal marital status**, including marriage, divorce, legal separation (where permissible by law), annulment or death of a Spouse.
2. **Change in number of Dependents**, including birth, adoption, placement for adoption, or death of a Dependent Child.
3. **Change in employment status or work schedule**, including the start or termination of employment by you, your Spouse or any Dependent Child, a strike or lockout, **or** the start of or return from an unpaid leave of absence. In addition, any change in the employment status of you, your Spouse, or your Dependent that results in that individual losing or gaining eligibility under this Plan will constitute a change in status affecting your benefit needs.
4. **Change in Dependent status under the terms of this Plan**, including becoming or ceasing to be a "Dependent" as that term is defined in the Definitions chapter of this document.
5. **Change of residence or worksite** that allows or impairs your, your Spouse or Dependent Child's ability to obtain health care services of In-Network Providers.
6. **Change required under the terms of a Qualified Medical Child Support Order (QMCSO)**, including a change to add coverage for the child, to provide the coverage specified in the order, or to cancel coverage for the child if the order requires your former Spouse to provide coverage for the child.

7. **Change consistent with your right to Special Enrollment** as described in Special Enrollment in the Eligibility chapter.

8. **Change in cost**.

   a. **Automatic changes for cost.** If the cost of this Plan increases (or decreases) during a Plan Year, and under the terms of the Plan you are required to make a corresponding change in your contributions, the Fund may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elective contributions for the plan.

   b. **Significant changes in cost.** If the cost of a benefit package option significantly increases during a Plan Year, you may either make a corresponding prospective increase in your contributions, or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option providing similar coverage.

9. **Significant changes in coverage.**

   a. **Significant curtailment.** If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections under the Plan. In that case, you may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants generally.

   b. **Addition or elimination of a benefit package option providing similar coverage.** If during a Plan Year the Fund adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) you may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

10. **Changes in Spouse, Former Spouse, or Dependent's coverage.** You may make a change in coverage if it is on account of and corresponds with a change made under a plan of Your Spouse, Former Spouse or Dependent for one of the following reasons:

    a. If the change is permitted under federal cafeteria plan regulations; or

    b. If the plan of the Spouse, Former Spouse, or Dependent's employer permits Participants to make an election for a period of coverage that is different from the Plan Year under this Plan.

11. **Reduction of Hours**. An employee who was expected to average at least 30 hours of service per week may prospectively drop group health plan coverage midyear if the employee's status changes so that the employee is expected to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan. However, the mid-year change must correspond to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage (MEC).

    The new MEC coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped. For example, other minimum essential coverage could mean intended enrollment in Health Insurance Marketplace coverage, minimum essential coverage through the spouse's group health plan, to change to a different medical plan option of the employee's own employer or to enroll in Medicaid/CHIP.

12. **Exchange Coverage.** An employee who is eligible to enroll in Marketplace coverage (during a Marketplace special enrollment or open enrollment period) may prospectively drop the Fund's group health plan coverage midyear, but only if the change corresponds to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Marketplace coverage that is effective no later than the day after the last day of the original coverage. This means that the Fund's group health plan coverage is not to be terminated until Marketplace coverage takes effect.

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. Generally, proof of the permitted election change event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

If you experience the following Event...	You may make the following change(s) within 31 days of the Event.	YOU MAY NOT make these types of changes...
REMINDER: *Failure to notify the Plan within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right to elect COBRA continuation coverage.*		
Family Events		
Marriage	• Enroll yourself, if applicable • Enroll your new Spouse and other eligible dependents • Drop health coverage (to enroll in your Spouse's plan) • Change health plans, when options are available	• Drop health coverage and not enroll in Spouse's plan.
Divorce	• Remove your Spouse from your health coverage • Enroll yourself (and your children) if you or they were previously enrolled in your Spouse's plan	• Change health plans • Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents • Change health plans, when options are available	• Drop health coverage for yourself or any other covered individuals
Child requires coverage due to a QMCSO	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO
Loss of a Dependent's eligibility (*e.g.,* child reaches the maximum age for coverage)	• Remove the Dependent from your health coverage • Dependent will be offered COBRA. You may pay for dependent's COBRA coverage on a pre-tax basis.	• Change health plans • Drop health coverage for yourself or any other covered individuals
Death of a dependent (Spouse or child)	• Remove the dependent from your health coverage • Change health plans, when options are available	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to (or lost entitlement to) Medicaid or Medicare	• Drop coverage for the person who became entitled to Medicare or Medicaid. • Add the person who lost Medicare/Medicaid entitlement.	• Drop health coverage for yourself or any other covered individuals
Employment Status Events		
Spouse becomes eligible for health benefits in another group health plan	• Remove your Spouse from your health coverage, with proof of Spouse's other new plan coverage • Remove your children from your health coverage, with proof of children's other new plan coverage • Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan	• Change health plans • Add any eligible dependents to your health coverage
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	• Enroll your Spouse and, if applicable, eligible children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's plan • Change health plans, when options are available	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your Spouse's plan, if available • Elect temporary COBRA coverage for the Qualified Beneficiaries (you and your covered Dependents)	
Proof of a status change may be required to make a corresponding change in coverage/enrollment.		

These rules apply to making changes to your benefit coverages during the year:

1. Any change you make to your benefits must be determined by the Plan Administrator or its designee to be necessary, appropriate to and consistent with the change in status. *(*For example, if mid-year, the employee and Spouse deliver a newborn child they can add that child to this Plan but it would be inconsistent with a birth event to drop the Spouse from coverage at this time); **and**
2. You must notify the Plan Administrator and/or PacifiCorp's Employee Benefits Department in writing **within 31 days** of the qualifying change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage on a pre-tax basis. You have 60 days from the loss of eligibility for Medicaid or CHIP to request to enroll in this Plan as discussed under Special Enrollment); **and**
3. If you have a qualifying change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. Generally, only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year from this Plan; **and**
4. Coverage changes associated with a mid-year change of status opportunity **are effective prospectively, on the first day of the month following receipt of the change of status form/online request** to PacifiCorp's Employee Benefits Department, (except for newborns who are effective on the date of birth and children adopted or placed for adoption who are effective on the date of adoption or placement for adoption).

RETURN TO WORK AND BENEFIT CONTINUATION ISSUES

If you cease to be a benefits-eligible Employee and then within 31 days return to work in a benefits-eligible position, then you will be required to take the same benefit election for the remaining portion of the Plan Year as you had before you terminated. Participation shall be effective the first of the month following such election.

If you cease to be a benefits-eligible Employee and return to work in a benefits-eligible position more than 31 days following the termination you will be permitted to make a new benefit election for the remaining portion of the Plan Year. Participation shall be effective the first of the month following such election.

WHEN COVERAGE ENDS

Active Employee coverage ends on the last day of the month in which:

- the Active Employee ceases to be actively engaged in employment with PacifiCorp d.b.a. Rocky Mountain Power and Pacific Power (note coverage may temporarily be continued under COBRA); or
- the Active Employee is no longer in a benefits eligible position with PacifiCorp d.b.a. Rocky Mountain Power and Pacific Power; or
- any required contribution for coverage is not received in a timely manner; or
- the date of the Active Employee's death; or
- the Plan is discontinued.

See also the Life Insurance section of this document regarding when Employee life insurance ends.

Dependent coverage ends on the earliest of the last day of the month in which:

- Active Employee coverage ends; or
- the covered Spouse or Dependent Child(ren) no longer meet the definition of Spouse or Dependent Child(ren) as provided in the Definitions chapter of this document; or
- the Dependent Spouse enters the Armed Forces on full-time active duty; or
- any required contribution for coverage is not received in a timely manner; or
- the Plan is discontinued.

For former employees receiving a disability payment under the Long Term Disability insurance program sponsored by the employer, coverage ends on the last day of the month in which:

- the former Employee ceases to be eligible to receive disability payments; or
- contributions for that month are received; or
- the date of the former Employee's death; or
- the Plan is discontinued.

For termination of coverage for a Surviving Dependent, see the section on Surviving Spouse and Dependent Children earlier in this chapter.

When coverage under this Plan terminates you may have the option to buy temporary continuation of this group health plan coverage by electing COBRA, or you can look into your options to buy an individual insurance policy for health care coverage from the **Health Insurance Marketplace**.

- As a reminder, starting in 2014, the Affordable Care Act (ACA) requires that most individuals maintain health insurance coverage or pay a tax penalty (referred to as the **Individual Mandate**). This Individual Mandate is a provision of the federal health law that requires you, your children and anyone else that you claim as a dependent on your taxes to have health coverage or pay a penalty. That coverage can be group health coverage available from an employer, Medicare, Medicaid, or an individual policy that you purchase.

For more information on the Individual Mandate, talk with your tax advisor or visit www.healthcare.gov. When coverage under this Plan terminates, remember that you have options to consider in order to avoid the Individual Mandate penalty.

WHEN THE FUND CAN END YOUR COVERAGE FOR CAUSE

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when employer 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 your coverage (retroactively to the date that you or your covered Dependent performed or permitted the acts described below) and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent:

   - **engages 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. Keeping an ineligible dependent enrolled under the Plan (for example, an ex-spouse, over-age or ineligible dependent child, etc.) is considered fraud; or
   - **allowed anyone else to use the identification card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or
   - **altered any prescription** furnished by a Physician or other Health Care Practitioner.

   If your coverage is terminated for any of the above reasons, it will be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

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

C. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 15 days after it gives you written notice of its finding that you have failed to pay your premium payment. In this instance, your coverage will be terminated retroactively to the date of the delinquent premium payment. In addition, your coverage may be suspended during the 15-day notice period.

NOTICE TO THE FUND (When Rights of Your Covered Dependents May End)

In order to process a request for COBRA benefits, you, your Spouse, or any of your Dependent Children **must notify the Fund in writing as soon as possible but no later than 60 days** after the date of:

- A divorce, legal separation or annulment;
- A Dependent Child ceases to meet the definition of Dependent as defined in the Definitions chapter of this document, such as the child reaches the Fund's limiting age.

Failure to give notice within the timeframe noted above may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage. For information regarding other notices you must furnish to the Fund, see the General Provisions chapter of this document.

LEAVE OF ABSENCE (Special Circumstances)

Family and/or Medical Leave (FMLA): In general, to be eligible for FMLA, an employee must have worked for their employer for at least 12 months, met the 1,250 hours of service requirement in the 12 months prior to the leave, and worked at a location where the employer employed at least 50 employees within 75 miles. If the employee is eligible for FMLA the employee is entitled by law to up to 12 weeks each year (in some cases up to 26 weeks) of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a Spouse, child or parent who is seriously ill, or for your own serious illness. The Fund uses a rolling 12-month period measured backwards from the date an Employee uses any FMLA leave.

While you are officially on such a family or medical leave, you can keep coverage for yourself and your Dependents in effect during that family or medical leave period by continuing to pay your contributions during that period. Since you will not be paid

while you are on family or medical leave, you may pay your contributions on a monthly basis, in which case your contributions will be made on an after-tax basis.

Whether or not you keep your coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your coverage will be reinstated (if applicable) without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Dependents who were covered by the Fund at the time you took your leave.

Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Dependents in the same way they apply to all other Employees and their Dependents. To find out more about your entitlement to family or medical leave as required by federal and/or state law, and the terms on which you may be entitled to it, contact your Employer.

FMLA and COBRA: Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur **after** the FMLA period expires, **if** the Employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the Employee notifies their Employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

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

If you go into active military service for **up to 31 days**, you can continue your health care coverage under this Plan during that leave period if you continue to pay your contributions for that coverage during the period of that leave. If you go into active military service for **more than 31 days**, you should receive military health care coverage at no cost; however, you may also continue this group health plan coverage under the provisions of USERRA, at your own expense up to a **maximum period of 24 months.** When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible Dependents **may elect either temporary continuation of coverage under USERRA or COBRA**. See also the COBRA chapter of this document. Questions regarding your entitlement to this leave and to the continuation of health care coverage should be referred to your Employer.

Reinstatement of Coverage After Leaves of Absence:

If your coverage ends while you are on an approved leave of absence for family, medical or military leave, if you are benefits-eligible upon return, your coverage will be reinstated on the day you return to active employment, if you return within 14 days after your leave of absence ends, subject to all accumulated Maximum Plan Benefits that were incurred prior to the leave of absence. Any period of any approved leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act will **not** be counted as a Break in Coverage. Questions regarding your entitlement to an approved leave of absence and to the continuation of medical, vision and dental coverage should be referred to the Employer.

CONTINUATION OF COVERAGE

There is no extension of benefits provision under this Plan. To temporarily continue benefits when coverage ends, see the COBRA chapter.

4. MEDICAL PLAN OPTIONS

There are various medical plan options available to Plan Participants: the Premium Health Plan, the Premium Plus Plan, the Comprehensive Health Plan, the Consumer Driven Health Plan/HSA, and, for Local 125 (union employee) participants, the insured HMO Medical Plan (HMO benefits are described in a separate document available from the Claims Administrator). These non-HMO plan options (described in this document) provide you with in-network and out-of-network benefits.

This document describes the Premium Health Plan, Premium Plus Plan, Comprehensive Health Plan and the Consumer Driven Health Plan/HSA options. These medical plan options all cover the same comprehensive types of services, such as Physician visits, hospitalization, emergency services, medical equipment, preventive care, and outpatient prescription drugs. What varies between the medical plans is:

a) your monthly premium/contributions for medical coverage, and

b) the amount of cost-sharing you may have.

Cost-sharing refers to deductibles, copayments, coinsurance and out-of-pocket limits.

The Schedule of Medical Benefits for each medical plan option explains the details about what is covered and your cost-sharing for that medical plan coverage. In all the medical plan options there is no out-of-pocket limit on the use of non-network providers and, preventive care is paid at no cost to you when you use an in-network provider.

Employees enrolled in the Premium Health Plan, Premium Plus Plan or the Comprehensive Health Plan may elect to enroll themselves and their eligible Dependents in Dental Plan and Vision Plan benefits.

One of the medical plans, the Consumer Driven Health Plan (CDHP), is a High Deductible Health Plan. The CDHP provides the same comprehensive types of services as the other medical plan options, but has a higher deductible than the other medical plans because the CDHP is designed to be able to be paired with a Health Savings Account (HSA). Later in this chapter there is more information about Health Savings Accounts.

NETWORK HEALTH CARE PROVIDERS

- **In-Network PPO Health Care Providers** (including hospitals, physicians and other ancillary health care providers) have agreements with the PPO and the Fund so that they provide health care services and supplies to Plan Participants with a favorably negotiated discount. If you use the services of an in-network PPO provider you will be responsible for paying less money out of your pocket.

  Health Care Providers who are members of the PPO have agreed to accept the amounts the Fund pays for covered services, plus any additional copayments or coinsurance you are responsible for paying, as payment in full.

  Note that **PPO providers are available in the Premium Health Plan, the Premium Plus Plan, the Comprehensive Health Plan and the Consumer Driven Health Plan**. PPO Providers are also referred to as In-Network Providers.

  Service Area:

  The "Service Area" is defined by the PPO network and refers to the geographic area serviced by the In-Network Health Care Providers who have agreements with the Plan's PPO. Starting in January 2017, all areas of the state of Utah are considered to be within the Service Area. This means that any member who resides anywhere in Utah is in the "Service Area" and any service received by an Out-of-Network provider in Utah will be paid at the Out-of-Network level of benefits.

  Reasonable Access:

  If Reasonable Access (defined below) to an in-network provider cannot be obtained, eligible charges from the out-of-network provider will be processed at the in-network level of benefits. Note that if you reside outside the Service Area and you travel back into the Service Area, eligible claims from out-of-network providers inside the Service Area will not be processed at the in-network level of benefits and instead the Out-of-Network level of benefits will apply because you are inside the network Service Area.

  "Reasonable Access" means the first available appointment for the following:

  – **Emergency Care:** life-threatening health condition. Not appropriate for provider office. Care typically not appropriate for an office visit and patient should seek immediate emergency care such as in an emergency room.

  – **Urgent Care:** recent onset of acute non-life threatening symptoms that need prompt but not immediate care. Access to provider within 24 hours or referral to or use of an urgent care facility. *Examples: persistent vomiting, prolonged diarrhea, minor fracture, minor laceration, fever.*

- **Non-Urgent Symptomatic Care:** non-acute and non-life threatening, bothersome or illness/disabling condition has persisted for more than a week. Access to provider within three to seven days. *Examples: rash, fatigue, persistent sore throat, cold/flu symptoms*.
- **Routine Care:** follow-up care after initial treatment. Access to provider within 14 days. *Examples: blood pressure recheck, medication regulation*.
- **Preventive/Wellness Care:** Access to provider within 30 days. *Examples: physical exams, immunizations, pap smear*.

NOTE:

- It is understood that some patients will not find the first available appointment to be convenient or desirable for their schedule.
- While the above timeframes are Reasonable Access guidelines, it may be that for some communities there are limited number of certain types of health care providers (e.g., specialty physicians) making the normative duration of time to obtain the first available appointment in that community exceed the access timeframes noted above.

- **Out-of-Network Health Care Providers** have no agreements with the Fund and are generally free to set their own charges for the services or supplies they provide. Upon submission of an itemized bill, the Fund will reimburse the Plan Participant for the Allowed Charge for any Medically Necessary covered services or supplies, subject to the Plan's Deductibles, Coinsurance, Copayments, Limitations and Exclusions. Plan Participants must submit proof of claim before any such reimbursement will be made.

  Out-of-Network Health Care Providers may bill the Plan Participant for any balance that may be due in addition to the amount payable by the Fund, also called balance billing. You can avoid balance billing by using in-network providers.

  Before you obtain services or supplies from an Out-of-Network provider you can find out whether the Fund will provide in-network or out-of-network benefits by contacting the Claims Administrator (or for prescriptions, the Prescription Drug Provider) as shown on the Quick Reference Chart in the front of this document.

Under the Premium Plan, the Premium Plus Plan, the Comprehensive Health Plan and the Consumer Driven Health Plan if you are admitted in a life-threatening medical emergency to an out-of-network hospital (such as through the emergency room), the Fund will allow payment of that hospital admission and the associated inpatient physician providers at the in-network level of benefits. Services provided after discharge will be paid at the out-of-network level of benefits.

See the Schedule of Medical Benefits for information on how the Fund pays benefits in and out of network.

IN-NETWORK CARE

Care received in a community is covered at the in-network level of benefit when the care is received through an in-network provider located in that community. It is desired that such care is provided through a network provider; however, the use of any appropriate provider (an out-of-network provider) will be covered by the Fund at the in-network benefit level if:

1. There are no appropriate in-network providers in the community where the care is received, or
2. The care is a result of an Emergency as defined under Emergency Care in the Definitions Chapter and care was received at the closest available provider.

For care received outside your community of residence, it is contemplated that such care is unscheduled, and a result of a need while traveling, vs. care that is scheduled and an individual travels to receive the care from an out-of-network provider. In the latter event, the coverage for such care will be treated as out-of-network care.

"Community" refers to the general metropolitan area where an insured participant resides. In the event an individual resides in a City or its suburbs, "Community" refers to the city and its suburbs. In the event an individual resides in a town, village, or collection thereof, "Community" refers to the town, village, or collection thereof.

REMINDER: if you reside outside the Service Area and you travel back into the Service Area, eligible claims from out-of-network providers inside the Service Area will not be processed at the in-network level of benefits and instead the Out-of-Network level of benefits will apply because you are inside the network Service Area.

DIRECTORIES OF NETWORK PROVIDERS

Upon initial enrollment in the Plan, you can obtain access to the Fund's PPO Network Providers by telephone (at no cost to you) or website as listed in the Quick Reference Chart.

- Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year.

- At any time, you can find out if any Health Care Provider is a member of the Network by checking the website of the PPO Network Administrator or by calling the Administrative Office at their telephone number shown on the Quick Reference Chart in the Introduction chapter of this document.

SPECIAL REIMBURSEMENT PROVISIONS

The following chart explains the Fund's special reimbursement for services when Out-of-Network providers/facilities are used. The Plan Administrator or its designee determines if and when the following special reimbursement circumstances apply to a claim. Medical records may be requested in order to assist with a determination on the need for special reimbursement provisions. Allowed Charge is defined in the Definitions chapter of this document.

Special Reimbursement Provisions	What The Fund Pays *(toward eligible claims submitted by an out-of-network provider)*
• Ancillary services (including but not limited to professional fees related to radiology, anesthesia, pathology, lab, emergency room physician, assistant surgeon) received from an Out-of-Network provider in connection with a visit to or surgery or service performed by an In-Network provider, if the choice of the Out-of-Network provider who performed the ancillary service was outside the patient's control. For example, the In-Network provider accidentally sends the patient's lab work to an Out-of-Network lab for processing or an Out-of-Network anesthesiologist provides anesthesia during surgery performed by an in-network physician. • There is no In-Network facility/provider qualified by area of professional specialty or practice available to provide Medically Necessary eligible health care services.	• As if the care was provided In-Network including deductible, coinsurance, copays and Out-of-Pocket Maximums and the allowance for bills will be reimbursed according to the Allowed Charge allowance for non-network providers. • See the definition of Allowed Charge in the Definitions chapter of this Plan.
• Use of an Out-of-Network provider when an In-Network provider was available to be used.	• The care was provided Out-of-Network and Out-of-Network reimbursement, including deductible, coinsurance, and copays will apply.

ONE-YEAR TRANSITION OF CARE PROVISION (Transition Period)

The Fund honors a one-year period for transition of care for participants who are newly enrolled in the Fund because of a merger of Funds. This one-year period allows these new participants to gradually transition their care from an out-of-network provider to an in-network provider. Benefit payments during this transition period are as follows:

- **Premium Health Plan:** Eligible expenses for use of an out-of-network provider are subject to the in-network deductible and then the Fund pays 80% of the Allowed Charge up to the level of the in-network Out-of-Pocket Maximum, thereafter the coinsurance payable by the Fund is 90% to the end of the transition period. Copays for out-of-network providers are considered at the in-network level of benefits during this transition period.
- **The Premium Plus Plan:** Eligible expenses for use of an out-of-network provider are subject to the in-network deductible and then the Fund pays 80% of the Allowed Charge up to the level of the in-network Out-of-Pocket Maximum, thereafter the coinsurance payable by the Fund is 90% to the end of the transition period. Copays for out-of-network providers are considered at the in-network level of benefits during this transition period.
- **Comprehensive Health Plan:** Eligible expenses for use of an out-of-network provider are subject to the in-network deductible and then the Fund pays 80% of the Allowed Charge up to the level of the in-network Out-of-Pocket Maximum, thereafter the coinsurance payable by the Fund is 90% to the end of the transition period. Copays for out-of-network providers are considered at the in-network level of benefits during this transition period.
- **Consumer Driven Health Plan:** Eligible expenses for use of an out-of-network provider are subject to the in-network deductible and then the Fund pays 80% of the Allowed Charge up to the level of the in-network Out-of-Pocket Maximum, thereafter the coinsurance payable by the Fund is 90% to the end of the transition period.

Upon completion of the one-year transition period benefits payments revert back to the normal Plan design as described in this chapter and in the Schedule of Medical Benefits.

ELIGIBLE MEDICAL EXPENSES

Under any of the medical plan options you are covered for expenses you incur for many, but not all, medical services and supplies. The expenses for which you are covered are called "Eligible Medical Expenses," and they are limited to those that are:

1. Determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that the charges are **"Allowed Charges"** (as those terms are defined in the Definitions chapter of this document); and
2. **Not services or supplies that are excluded** from coverage (as provided in the Exclusions chapter of this document); and
3. **Services or supplies the charges for which are not in excess** of a Maximum Plan Benefit shown in the Schedule of Medical Benefits.

Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have incurred a maximum out-of-pocket cost applicable only to the Coinsurance for in-network services, no further Coinsurance will be applied.

There are certain Limited Overall Maximum Plan Benefits and Annual Maximum Plan Benefits. These features are outlined in further detail in this chapter and are also described in the Schedules of Medical Benefits.

NON-ELIGIBLE MEDICAL EXPENSES

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are:

- Not determined to be Medically Necessary,
- Determined to be in excess of the Allowed Charges,
- Not covered by the Plan,
- In excess of any applicable Maximum Plan Benefits, or
- Payable on account of failure to comply with the Plan's Utilization Management requirements as described later in this document.

DEDUCTIBLES

Each Calendar Year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are received by the Plan. The amount applied to the deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan. Deductibles under this Plan are accumulated on a Calendar Year basis.

Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses (described on the prior page) do not count toward the Deductibles. Copayments are also not applied to meet the deductible.

There are **two main types of Deductibles: Individual and Family**.

- The **Individual Deductible** is the maximum amount one covered person has to pay toward Eligible Medical Expenses before benefits begin. The Plan's Individual Deductible varies depending on which medical plan option you choose. See the Schedule of Medical Benefits for details.
- The **Family Deductible** is the maximum amount that a family of two or more is responsible for paying toward Eligible Medical Expenses before benefits begin. The Plan's Family Deductible varies depending on which medical plan option you choose. See the Schedule of Medical Benefits for details.

> **NOTE:** For families enrolled in the HDHP option, IRS regulations require that the family (**including any individual in the family**) must meet the IRS-mandated minimum family deductible (e.g. $2,700 in 2018) before any reimbursement is made for eligible medical expenses (other than for preventive care).

Note that services from In-Network and Out-of-Network providers are combined to meet your annual deductible amounts.

Outpatient Prescription Drug Deductible:

All medical plan options use the same Prescription Drug Program to administer outpatient retail and mail order drugs. There is a separate individual and family annual outpatient prescription drug deductible that must be met each calendar year (when enrolled in the Premium Health Plan, Premium Plus Plan or Comprehensive Health Plan) before the Plan pays outpatient prescription drugs, as outlined in the Drug row of the Schedule of Medical Benefits.

Expenses Not Subject to Deductibles: Certain Eligible Medical Expenses are not subject to Deductibles. See the Schedule of Medical Benefits to determine when Eligible Medical Expenses are not subject to Deductibles.

Deductible Rules when Enrolled in the Consumer Driven Health Plan/HSA: If you are enrolled in the Consumer Driven Health Plan/HSA option, this Plan option is not permitted to pay ANY benefits (except certain preventive/wellness care outlined in the Preventive Services Program in the Wellness row of the Schedule of Medical Benefits and certain prescriptions for maintenance/preventive purposes such as for high blood pressure, diabetes, high cholesterol, asthma) until your deductible has been met. Under this Consumer Driven Health Plan/HSA option, your copayments, if any, do not accumulate to meet your annual deductible.

Credit toward Deductible: When an Employee transfers during a calendar year from the PacifiCorp Plan to this Plan, the Plan will give credit for eligible expenses that have been incurred by the Employee and/or eligible Dependent(s) under the current PacifiCorp Plan year toward the satisfaction of this Plan's annual deductible.

COINSURANCE

Once you've met your annual Deductible, the Plan generally pays a large percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. If you use the services of a Health Care Provider who is a member of the Plan's PPO, you will be responsible for paying less money out of your pocket. This feature is described in more detail in the Medical Network chapter and Schedule of Medical Benefits charts in this document.

COPAYMENT

A Copayment (or Copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan's Copayments are indicated in the Schedule of Medical Benefits. Copayments are not credited to satisfy the deductible or Out-of-Pocket Maximum. Copayments will continue to be your responsibility even after you reach your annual Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM FOR COINSURANCE

Medical Plan Out-of-Pocket Maximum:

Each Calendar Year, after an individual or family has incurred a maximum Out-of-Pocket cost **for coinsurance** associated with the Premium Plan, the Premium Plus Plan, the Comprehensive Health Plan, or the Outpatient Retail and Specialty Prescription Drug benefits of the Premium Plan or the Premium Plus Plan, the Plan will pay more of your covered Eligible Medical Expenses, **except for** the expenses listed below that are not included in the Out-of-Pocket Maximum.

See the Schedule of Medical Benefits for the amount of the Out-of-Pocket Maximum, as it varies by the medical plan option you choose and whether you use in-network or out-of-network providers. For example, once the Out-of-Pocket maximum is reached, the Plan pays **100% toward in-network providers** but only **90% toward out-of-network providers**.

The Out-of-Pocket Maximum does not include or accumulate:

a. Any plan **Deductible**.
b. Any applicable **Copayments**.
c. All expenses for medical services or supplies that are **not covered** by the Plan.
d. All charges **in excess of the Allowed Charge** determined by the Plan.
e. All charges **in excess of the Plan's Maximum Benefits**, or in excess of any other maximum or limitation of the Plan.
f. Any additional other amounts you have to pay because you **failed to comply with the Utilization Management Programs** described in the Utilization Management chapter of this document.
g. All expenses including copays and coinsurance for **Outpatient Prescription Drugs**.
h. **Premiums or contributions** for coverage.
i. **Dental Plan and Vision Plan** expenses.
j. Expenses for a **non-network provider** (except that emergency services performed in a non-network emergency room will accumulate to the in-network out-of-pocket limit for coinsurance).

Note that services from In-Network and Out-of-Network providers are NOT combined to meet your annual Out-of-Pocket Maximum for Coinsurance for all medical plan options.

Outpatient Prescription Drug Out-of-Pocket Maximum on Coinsurance:

All medical plan options use the same Prescription Drug Program to administer outpatient retail and mail order drugs. For two of the medical plan options (Premium Plan and Premium Plus Plan) there is a separate individual and family annual Out-of-Pocket Maximum on Coinsurance applied to outpatient prescription drugs that must be met each calendar year before the Plan pays outpatient prescription drugs at 100%. The deductible and copays do not accumulate to meet this outpatient prescription drug Out-of-Pocket Maximum on Coinsurance. This is outlined in the Drug row of the Schedule of Medical Benefits.

The Comprehensive Health Plan and the Consumer Driven Health Plan do not have a specific out-of-pocket maximum for coinsurance associated with outpatient prescription drugs.

Credit toward Out-of-Pocket Maximums:

When an Employee transfers during a calendar year from the PacifiCorp Plan to this Plan, the Plan will give credit for eligible expenses that have been incurred by the Employee and/or eligible Dependent(s) under the current PacifiCorp Plan year toward the satisfaction of this Plan's annual Out-of-Pocket Maximum.

4

OUT-OF-POCKET LIMIT ON IN-NETWORK COST-SHARING

This Out-of-Pocket Limit is the maximum amount of cost-sharing in the form of deductibles, copayment and coinsurance you are responsible for paying each calendar year related to in-network essential health benefits, before the Plan pays the remainder of your eligible claims that year. Some out-of-pocket expenses do not apply to this limit as described below.

The Out-of-Pocket Limit is accumulated on a calendar year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Plan. Effective January 1, 2015, covered outpatient drugs accumulate to the in-network cost-sharing Out-of-Pocket Limit.

The amount of the Out-of-Pocket Limit is explained in the various Schedule of Medical Benefits in this document. For each of the medical plan options, the family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.

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

a. **Premiums or contributions** for coverage,
b. Expenses for medical services or supplies that are **not covered** by the Plan,
c. **Charges in excess of the Allowed Charge** determined by the Plan which includes balance billed amounts for non-network providers,
d. **Penalties for non-compliance** with Utilization Management programs,
e. Expenses for the **use of a non-network provider**, except emergency services performed in an out-of-network Emergency Room will accumulate to the in-network Out-of-Pocket Limit on Cost-sharing,
f. Charges **in excess of the Medical Plan's Maximum Benefits**,
g. **Dental Plan and Vision Plan** expenses.
h. Certain services or items with respect to which the Plan exercises its discretion to define as **not "Essential Health Benefits"** including but not limited to:
    1) An individual's **out-of-pocket costs for a brand name prescription drug in circumstances in which** a generic was available and medically appropriate. The difference between the cost of the brand name drug and the cost of the generic drug will not be counted toward your Out of-Pocket Limit. In determining whether a generic is medically appropriate, the Plan will use a reasonable exception process, for example, the Plan may defer to the recommendation of an individual's personal physician, or it may offer an exceptions process meeting the requirements of 45 CFR 156.122(c).
    2) Any service or item for which the **Plan imposes an annual maximum**, for example, acupuncture, and chiropractic.

MAXIMUM PLAN BENEFITS

Types of Maximum Plan Benefits: There are two types of maximum amounts of benefits payable by the Plan on account of medical expenses incurred by any covered Plan Participant under this Plan. They are described in detail in the following sections, and they are: Limited Overall Maximum Plan Benefits and Annual Maximum Plan Benefits.

- **Limited Overall Maximum Plan Benefits:** Plan benefits for certain Eligible Medical Expenses are subject to Limited Overall Maximums for each Covered Individual. Once the Plan has paid the Limited Overall Maximum Plan Benefits for any of those services or supplies on behalf of any Covered Individual, it will not pay any further Plan benefits for those services or supplies on account of that Covered Individual. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of the Limited Overall Maximum Plan Benefits are identified in the Schedule of Medical Benefits.

- **Annual Maximum Plan Benefits:** Plan benefits for certain Eligible Medical Expenses are subject to Annual Maximums per Covered Individual or family during each Calendar Year. Once the Plan has paid the Annual Maximum Plan Benefits for any of those services or supplies on behalf of any Covered Individual or family, it will not pay any further benefits for those services or supplies on account of that Individual or family for the balance of the Calendar Year. The services or supplies that are subject to Annual Maximum Plan Benefits are identified in the Schedule of Medical Benefits.

CONSUMER DRIVEN HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT (HSA)

The Consumer Driven Health Plan is a High Deductible Health Plan (HDHP) that is intended to comply with Code §223(c)(2) to allow the Trust Fund (when applicable) and eligible employees to make contributions to a Health Savings Account (HSA). The High Deductible Health Plan has a specific design for the Deductible and Out-of-Pocket Limit and this design is adjusted annually in connection with applicable IRS rules, and as appropriate for Plan administration.

An HSA is an account owned by an employee. Money deposited into the health savings account can be used (tax-free) by the employee only for qualified medical expenses. To be reimbursed on a tax-free basis, qualified medical expenses must be incurred **after** the HSA has been established. The HSA Administrator (whose contact information is listed on the Quick Reference Chart in the front of this document) provides members with 24/7 toll-free access to account services through its Member Services group. Additionally, many questions can be answered by going to the HSA Administrator's website which contains many resources for learning about starting and contributing to an HSA.

The IRS determines the types of eligible medical expenses that are permitted for tax-free withdrawals from the HSA and it is ultimately your responsibility to assure that you are complying with IRS rules. For information on what is an eligible medical expense, contact the HSA Administrator (whose contact information is listed on the Quick Reference Chart in the front of this document). The HSA account can also be used to buy non-qualified medical expenses but then the employee is required to pay applicable taxes and a financial penalty to the IRS.

THREE TAX SAVINGS OF A HEALTH SAVINGS ACCOUNT (HSA)

Health savings accounts (HSA) provide the HSA account owner with three tax savings:
(a) contributions to an HSA reduce their taxable income,
(b) earnings on the HSA account balance grows tax free and
(c) distributions from an HSA are not taxed for qualified expenses.

Note that, as of the date of this communication, the IRS code was not amended by PPACA Health Reform regulations to expand the definition of eligible dependents under Health Savings Accounts (HSA) to age 26. This means that employees may only be reimbursed from their tax-free HSA accounts for dependent children who meet the Internal Revenue Code definition of tax dependent (qualifying child or qualifying relative), which is a narrower definition than the applicable definition for federal Health Reform. Money withdrawn from the HSA account for dependent children who are not tax-qualified could cause the employee to be subject to income tax and a 20% penalty. The HSA participant is responsible for filing a proper return of tax and payment of taxes on taxable amounts.

The Board of Trustees does not provide tax advice and no inference may be made that the information contained here constitutes tax advice. The tax information contained in this document is for general guidance only and is subject to change due to changes in IRS rules and regulations. You should consult a qualified tax advisor with regard to any questions you may have about the tax effects of an HSA on your individual circumstances. The Board of Trustees assumes no responsibility for the accuracy of tax statements expressed in this document in relation to an individual's tax situation.

Under this Plan both you and the Trust Fund can contribute to the health savings account. However, contributions cannot begin until you take the necessary steps to open a health savings account. Annually, the Plan reserves the right to start, stop or adjust any contributions to a Health Savings Account. The amount of Trust Fund contribution, if any, will be in accordance with permissible government guidelines and is announced at the Open Enrollment period each year.

Each tax year the IRS announces the maximum amount of money that can be contributed to an individual's account (e.g. in 2018 the maximum is $3,450/individual and $6,900/family). Individuals age 55 and older can make additional "catch-up" contributions each year (for example, in 2018, the catch-up contributions cannot exceed $1,000). Unused money in the health savings account can grow the account balance because it can be rolled over year after year. The HSA is portable, meaning that the account belongs to you (the employee) even if you change employers or leave the workforce.

IMPORTANT:

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible." **IRS guidelines define an HSA Eligible individual as a person who:**

- **is covered under a HSA-qualified high deductible health plan (HDHP), and**
- **has "no other health coverage" (except what is permitted by the IRS), and**

- **is not enrolled in Medicare, and**
- **cannot be claimed as a dependent on someone else's tax return.**

"No other health coverage" means you cannot also be covered under your spouse's medical plan or by any general purpose Health Flexible Spending Account (Health FSA), any general purpose Health Reimbursement Account (HRA) or covered by another plan that pays medical benefits.

By law, you are not eligible for HSA contributions if you:

- ✓ are enrolled in Medicare (Part A, Part B, Part C -Medicare Advantage Plans, Part D, and Medigap, a Medicare Supplemental Insurance)*,
- ✓ are covered by another health care plan that is not a qualified high deductible health plan (HDHP),
- ✓ can be claimed as a dependent on someone else's tax return,
- ✓ are covered by a non-HDHP such as Medicaid, TRICARE or TRICARE for Life, or
- ✓ are enrolled in a general purpose Health Care Flexible Spending Account (or covered by a spouse's FSA).

4

*With respect to being enrolled in Medicare, HSA contributions generally should be discontinued at least six months prior to filing for Medicare benefits, because Medicare enrollment (called Medicare entitlement) can occur retroactively. If you do not stop HSA contributions six months before you apply for Social Security (applying for Social Security is a first step toward Medicare coverage), you may have a tax penalty. The penalty is because you were not supposed to put money into your HSA while you had Medicare coverage. So be sure to stop all contributions to your HSA up to six months before you collect Social Security benefits.

You could be enrolled in a Dental Plan or Vision plan, a Limited Scope Health Flexible Spending Account that reimburses dental and vision services only, a Dependent Care Flexible Spending Account Plan, and also could have automobile, disability or long-term care insurance coverage.

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA eligible."

Note that individuals who have a health savings account and are enrolled in Medicare can no longer contribute (or have Trust Fund contributions made) to the health savings account but can use the money they have accumulated in that account when they were HSA eligible.

Note about Use of an HSA Account for Dependent Child Expenses: To use funds in a health savings account to reimburse eligible medical expenses for a dependent child, the IRS requires that a HSA account holder must be able to "claim" the child as a dependent on their tax return. If the account holder cannot claim the child as a dependent, then HSA dollars cannot be used to pay for/reimburse services provided to that child. This means that you could cover your 24 year old child on the Consumer Driven Health Plan but not be able to use funds in your health savings account for that child if the child is not your tax-qualified dependent.

Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution: If you aren't certain you'll be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you're actually eligible in the current tax year. To do this, divide the yearly allowable maximum contribution by 12, then multiply the result by the number of months you're enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your HSA are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are considered to be an eligible individual for HSA contributions for the entire tax year and you are not required to prorate your contributions to your health savings account. However, if you base an entire tax year's contribution on your status on December 1 and you cease to be an eligible individual before the end of the following year, any funding of the health savings account over the prorated amount (for December) is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

A few states (like California, Alabama and New Jersey) may not conform their state tax laws with federal tax laws and contributions to the HSA may be taxed under these state laws. It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, **it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA account**.

Questions about the High Deductible Health Plan (called Consumer Driven Health Plan) described in this document can be directed to the Administrative Office and for the HSA to the HSA Administrator.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

If you and/or your Dependent(s) are entitled to Medicare Part A or Part B, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage for each medical plan outlined in this document is "creditable." "Creditable" means that the value of the Fund's prescription drug benefit is, on average for all Plan Participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because the Fund's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (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 you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefit chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period (however no Employee may decline medical coverage under this Plan except an employee hired through the Union's hiring hall, casual, temporary or a leased employee).

> **IMPORTANT NOTE**: If you are enrolled in the Consumer Driven Health Plan that is combined with the Health Savings Account (HSA), **under IRS regulations you and the Trust Fund are not permitted to continue to make contributions to your HSA once you are enrolled in Medicare,** including being enrolled in a Medicare Part D drug plan.

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following three times:

1. When they first become eligible for Medicare; or
2. During Medicare's annual election period (from October 15th through December 7th); or
3. For beneficiaries leaving employer union group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare prescription drug plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare prescription drug plan you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

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

The Medicare program has arranged to let employer-sponsored Plans who have filed for a subsidy know if their participants have tried to enroll in a Medicare Prescription Drug Plan. This is because many people with Medicare may not understand that they are able to keep their current employment based prescription drug coverage and do not need the Medicare Part D prescription drug coverage. If we find out that you have tried to enroll in a Medicare Prescription Drug Plan, we will contact you to see if that is your final decision or just an error.

CERTAIN OVER-THE-COUNTER (OTC) AND PRESCRIPTION DRUGS MANDATED FOR COVERAGE UNDER HEALTH REFORM

For an over-the-counter or prescription drug, listed below, to be covered by the Plan, the drug must be:

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

The following chart outlines the OTC and certain prescription drugs that are payable by the medical plans in this document, **at no charge when purchased from a network retail pharmacy location**, in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of OTC and prescription drugs, this Plan will comply with the new requirements on the date required.

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Drugs in addition to a prescription from your Physician or Health Care Practitioner:
Aspirin	• For men 45-79 years of age to reduce chance of a heart attack • For women 55-79 years of age to reduce the chance of a stroke. • For pregnant women who are at high risk for preeclampsia (a pregnancy complication). • Low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	None, if payment parameters are met	Since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months. For pregnant women at high risk for preeclampsia: daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation. The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
FDA-approved Contraceptives for females, such as spermicidal products and sponges.	All females	None, if payment parameters are met	Up to a month's supply of FDA-approved female contraceptives per purchase (or 3 month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the plan's Prescription Drug Program for females. Generic FDA-approved contraceptives are no cost. Brand contraceptives are payable only if a generic alternative is medically inappropriate. Drug Exception Process: The Plan has an exception process managed by the Prescription Drug Program administrator (whose contact information is listed on the Quick Reference Chart in the front of this document). The exception process allows a member's physician to contact the Prescription Drug Program administrator to request that a non-covered drug be payable under the Plan. The physician is to fax the request for a drug exception and the clinical reasons why the drug is needed, including why a covered drug cannot be used in its place, to the clinical team of the Prescription Drug Program administrator who will review and respond to the physician with their determination.
Folic acid supplements	All females planning or capable of pregnancy should take a daily folic acid supplement containing 0.4 - 0.8mg of folic acid.	None, if payment parameters are met	Excludes women >55 years of age, and products containing > 0.8mg or < 0.4mg of folic acid.
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling.	None, if payment parameters are met	Since dosage is not established by USPSTF, plan covers up to one bottle of 100 tablets every 3 months
Tobacco cessation products (FDA approved)	All covered individuals who use tobacco products.	None, if payment parameters are met	FDA-approved tobacco cessation drugs are payable under the plan's Prescription Drug Program, up to two 90-day courses of treatment per year, which applies to all products. No precertification or prior authorization is required
Fluoride supplements	For preschool children older than age 6 months when recommended by provider because primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Drugs in addition to a prescription from your Physician or Health Care Practitioner:
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a physician as preparation for a payable preventive colon cancer screening test, such as a screening colonoscopy.
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.	None, if payment parameters are met	For adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke), the Plan covers a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. • Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening (a lab test) in adults ages 40 to 75 years. • Brand statins are payable only if a generic alternative is medically inappropriate, as determined by the Physician or Health Care Practitioner.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The medical plan options in this document do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider.

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

NONDISCRIMINATION IN HEALTH CARE

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

SCHEDULE OF MEDICAL BENEFITS

A schedule of the Plan's Medical Benefits, appears on the following pages in a chart format. Two medical plan options are described on one chart and there is a separate chart to describe each of the other two medical plan option. Each of the Plan's medical benefits is described in the first column of the Schedule of Medical Benefits. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided by the various medical plan options and In-Network (when you use Network Providers) and Out-of-Network (when you use Out-of-Network Providers) are shown in the subsequent columns.

Hospital Services (Inpatient) and Physician and Health Care Practitioner Services are listed first because these two categories of benefits apply to most (but not all) health care services covered by the Plan. All other benefits are listed in alphabetical order. Unless there is a specific statement in the Schedule of Medical Benefits, all benefits shown are subject to the Plan's Deductibles.

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

The Consumer Driven Health Plan (CDHP) listed in this document is intended to qualify as a High Deductible Health Plan (HDHP) to comply with Code §223(c)(2) to allow eligible individuals (and, when applicable, the employer) to make contributions to a Health Savings Account (HSA).

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All medical plan post service claims must be submitted to the Plan within **ONE YEAR** from the date of service. No Plan benefits will be paid for any claim submitted after this period.

See also the Claim Filing and Appeal Information chapter for more information. Also review the section toward the end of that chapter on "Limitation On When A Lawsuit May Be Started."

4

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

- ✓ **Use Network (PPO) providers.** They charge less, and you pay less. And, Preventive Care is free when provided by Network PPO providers.
- ✓ **Choose Generic drugs when possible.** Ask your Doctor if a generic drug is appropriate for you. You'll pay less for generic drugs than for brand name drugs.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends for you. Make medication compliance your habit to a healthier life.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range), get tips from your provider on how to reduce your health risks, and stay current on recommended immunizations and cancer screening tests.
- ✓ **Not feeling well?** Call your Network Doctor's office for help. Or, use a Network Urgent Care facility instead of an emergency room (ER), if medically appropriate.
- ✓ **Precertify** your elective hospital admission, certain outpatient drugs, outpatient surgery, home health care, MRI/CT scan, and various other services to help avoid a financial penalty (as explained in Chapter 6).
- ✓ **Review Your Medical Bills.** If something on a medical bill just doesn't look right, contact the Administrative Office if you think there might be an error on a bill.

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

5. SCHEDULE OF MEDICAL BENEFITS

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE • Is the amount you must pay each calendar year before the Plan pays benefits. • Deductibles under this Plan are accumulated on a Calendar Year basis.	• Note that services from In-Network and Out-of-Network providers are combined to meet your annual deductible amounts. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are received by the Plan. • The amount applied to the deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan.	$250/person $750/family	$500/person $1,500/family	$250/person $750/family	$500/person $1,500/family
OUT-OF-POCKET MAXIMUM ON COINSURANCE • This Out-of-Pocket Maximum is the **maximum amount of coinsurance** you are responsible for paying each calendar year, in addition to the deductible and copays, **before** the Plan pays more of your eligible claims. Some out-of-pocket expenses do not apply to this maximum as described to the right. • A separate Out-of-Pocket Maximum on coinsurance applies to outpatient retail prescription drugs only in the Premium Health and Premium Plus plans. • **Note that services from In-Network and Out-of-Network providers are NOT combined to meet your annual Out-of-Pocket Maximum.**	**The Out-of-Pocket Maximum on Coinsurance does not include or accumulate:** a. Any plan **Deductible**. b. Any applicable **Copayments**. c. All expenses for medical services or supplies that are **not covered** by the Plan. d. All charges in **excess of the Allowed Charge** determined by the Plan. e. All charges in **excess of the Plan's Maximum Benefits**, or in excess of any other maximum or limitation of the Plan. f. Any additional other amounts you have to pay because you **failed to comply with the Utilization Management Programs** described in the Utilization Management chapter of this document. g. All expenses including copays and coinsurance for **Outpatient Prescription Drugs**. h. **Premiums and contributions** for coverage. i. **Dental Plan and Vision Plan** expenses. j. Expenses for a **non-network provider** (except that emergency services performed in a non-network emergency room will accumulate to the in-network out-of-pocket limit).	$1,000/person $2,000/family Once the maximum is reached the Plan pays 100% toward in-network providers.	No limit.	$500/person $1,000/family Once the maximum is reached the Plan pays 100% toward in-network providers.	No limit.

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
OUT-OF-POCKET LIMIT ON IN-NETWORK COST-SHARING • This Out-of-Pocket Limit is the **maximum amount of deductibles, copayment and coinsurance** you are responsible for paying each calendar year related to in-network essential health benefits, **before** the Plan pays the remainder of your eligible claims that year. • Some out-of-pocket expenses do not apply to this Out-of-Pocket Limit, as described to the right. • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person in a family" annual out-of-pocket limit.	• The Out-of-Pocket Limit is accumulated on a calendar year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Plan. • Effective January 1, 2015, covered outpatient drugs accumulate to the in-network cost-sharing Out-of-Pocket Limit. • **The Out-of-Pocket Limit DOES NOT INCLUDE or accumulate:** a. **Premiums and contributions** for coverage, b. Expenses for medical services or supplies that are **not covered** by the Plan, c. **Charges in excess of the Allowed Charge** determined by the Plan which includes balance billed amounts for non-network providers, d. **Penalties for non-compliance** with Utilization Management programs, e. Expenses for the **use of non-network providers**, except emergency services performed in an out-of-network Emergency Room will accumulate to the in-network Out-of-Pocket Limit, f. Charges **in excess of the Medical Plan's Maximum Benefits**, g. **Dental Plan and Vision Plan** expenses, h. Certain services or items with respect to which the Plan exercises its discretion to define as **not "Essential Health Benefits"** including but not limited to: 1) An individual's **out-of-pocket costs for a brand name prescription drug in circumstances in which** a generic was available and medically appropriate. The difference between the cost of the brand name drug and the cost of the generic drug will not be counted toward your Out of-Pocket Limit. In determining whether a generic is medically appropriate, the Plan will use a reasonable exception process, for example, the Plan may defer to the recommendation of an individual's personal physician, or it may offer an exceptions process meeting the requirements of 45 CFR 156.122(c). 2) Any service or item for which the **Plan imposes an annual maximum**, for example, acupuncture and chiropractic.	$6,600/person $6,600 per person in the family $13,200/family	No limit.	$6,600/person $6,600 per person in the family $13,200/family	No limit.

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
HOSPITAL SERVICES (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms.	• **Inpatient hospitalization is subject to precertification**. All Hospitalization is subject to concurrent review. See the Utilization Management chapter for details. There is a $200 penalty for failure to precertify. • Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services if the utilization Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or assistant dental provider fees under this medical plan. • See the Eligibility chapter for how to properly enroll Newborns so coverage can be considered.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

PHYSICIAN AND OTHER HEALTH CARE PRACTITIONER SERVICES
• Physician and Health Care Practitioner professional fees for services provided in a Hospital, Urgent Care Center, Health Care Facility, an office or at home, except as otherwise indicated in the Schedule of Medical Benefits.
• For payment of emergency services in an Emergency Room, see the Emergency Room row of this Schedule.
• Payable Physician and Health Care Practitioners include:
  • Surgeon;
  • Assistant surgeon (if Medically Necessary);
  • Anesthesia provided by Physicians and/or Certified Registered Nurse Anesthetists (CRNA);
  • Pathologist; Radiologist;
  • Physician Assistant; Nurse Practitioner; Nurse Midwife;
  • Podiatrist;
  • Breastfeeding/Lactation Educator (see the Maternity row for information.)
	• **Some Physician and Health Care Practitioner services are subject to precertification. Certain tests require precertification, such as Endoscopy and Colonoscopy.** See the Utilization Management chapter of this document for additional details.
	• The Plan Administrator or its designee will determine if multiple surgical or medical procedures will be covered as separate procedures or as a single procedure based on the definition of "Surgery" in the Definitions chapter.
	• Assistant Surgeons:
	– Physicians who act as an Assistant Surgeon will be reimbursed for Medically Necessary services to a maximum of **20%** of the eligible expenses payable to the primary surgeon.
	– All other health care practitioners who act as an Assistant Surgeon (e.g., physician assistant, nurse practitioner) will be reimbursed for Medically Necessary services to a maximum of **15%** of the eligible expenses payable to the primary surgeon. Certified Surgical Assistants (as defined by the Plan) are not payable.
	• See also "Prophylactic, Prophylactic Surgery" as defined in the Definitions chapter and the Prophylactic Surgery or Treatment Exclusions in the Exclusions chapter.
	• Coverage is provided for intravenous (IV) iron therapy when determined by the Plan to be Medically Necessary. **IV iron therapy requires precertification**. See the Utilization Management chapter for details on how to precertify.
	• Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
		Office Visit:
		100% after a $20 copay per visit.
		No deducible.
		
		All Other Services:
		90%
		after deductible
		met
			50%
			after deductible
			met
				Office Visit:
				100% after a $10 copay per visit.
				No deductible.
				
				All Other Services:
				90%
				after deductible
				met
					50%
					after deductible
					met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
ACUPUNCTURE	• Payable to a maximum of $500 per person per calendar year if services are ordered by a Physician. This benefit limit does not apply to acupuncture used as a treatment for tobacco cessation. • Services are covered only if the HealthCare Practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met
ALLERGY SERVICES • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician. Desensitization injections are covered only when provided by a licensed Health Care Practitioner.	Testing, Allergy Shots and Antigen: 90% after deductible met	Testing, Allergy Shots and Antigen: 50% after deductible met	Testing, Allergy Shots and Antigen: 90% after deductible met	Testing, Allergy Shots and Antigen: 50% after deductible met
AMBULANCE SERVICES • **Ground vehicle transportation** to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency, acute illness or inter-health care facility transfer. • **Air transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.	• Expenses for **ground vehicle ambulance services are covered only when those services are for an Emergency** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care." • Non-emergency medical transportation refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-emergency medical monitoring during transport. **Non-emergency medical transportation services are payable when precertified**.	90% after deductible met	90% after deductible met	90% after deductible met	90% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
BEHAVIORAL HEALTH SERVICES (Mental Health and Substance Abuse Treatment) • **EAP Services:** The Plan provides an EAP Program that offers up to **8 free counseling visits** to the EAP. Contact the EAP Program whose name is listed on the Quick Reference Chart. • **Behavioral Health Services:** – **Inpatient**: means hospitalization at a Behavioral Health Treatment Facility or hospital that provides an area dedicated to behavioral health treatment. Inpatient also includes an admission to an in-network residential treatment program (as the term is defined in the Definitions chapter). – **Outpatient**: means office visits. Other outpatient services include partial hospitalization and an intensive outpatient treatment program. – **Psychological (Psychiatric) Testing**. – **Chronic pain control and pain rehabilitation** payable as part of Behavioral Health Services. – **Applied Behavioral Analysis Therapy.** See the definitions chapter.	• **EAP Services:** The Plan provides an EAP Program. When you are enrolled in one of the medical plan options you and your Dependents are eligible to use the EAP services for information and/or free confidential counseling visits for a wide range of problems and illnesses including stress, depression, anxiety, work life issues, etc. EAP benefits are provided through a contracted EAP Program whose name and phone number are listed on the Quick Reference Chart in the Introduction chapter of this document. • **Inpatient hospitalization and residential treatment program admission requires precertification** by calling the Behavioral Health Program whose phone number is listed on the Quick Reference Chart in the front of this document. • **Residential treatment program** is covered (from in-network providers only) for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. See the definition of Residential Treatment Program. **Precertification is required**. • See the specific exclusions related to Behavioral Health Services in the Exclusions chapter. • Benefits are payable for services of Behavioral Health Care Practitioners listed in the Definitions chapter. • Outpatient prescription drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. • You may use these Behavioral Health services for counseling assistance for tobacco addiction.	**EAP:** 100% **Inpatient:** 90% after deductible met **Outpatient Office Visit**: 100% after a $20 copay per visit. No deductible. **All other services**: 90% after deductible met	**Residential Treatment Program:** No coverage. **All other services**: 50% after deductible met	**EAP:** 100% **Inpatient:** 90% after deductible met **Outpatient Office Visit:** 100% after a $10 copay per visit. No deductible. **All other services:** 90% after deductible met	**Residential Treatment Program:** No coverage. **All other services**: 50% after deductible met
BLOOD TRANSFUSIONS • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician and if blood is not replaced at the blood bank. • Expenses related to autologous blood donation (patient's own blood) are covered.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met
CHEMOTHERAPY • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.		90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met
CHIROPRACTIC SERVICES • Chiropractic services include office visits, x-rays and manipulations performed by a Chiropractor.	• Chiropractic services are payable to a maximum of $50 per visit not to exceed $500 per person per calendar year.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
CORRECTIVE APPLIANCES (Prosthetic and Orthotic Devices, Other Than Dental) • Coverage is provided for Medically Necessary corrective appliances as follows: – rental (but only up to the allowed purchase price of the device). – purchase of standard models at the option of the Plan. – repair, adjustment or servicing of the device or replacement of the device due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. • Colostomy or ostomy (orthotic) supplies. • Hearing Aid. • Corrective shoes or supportive devices for the feet including orthotics are not payable unless they are an integral part of a lower body brace.	• Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner. • **Prosthetic devices require precertification**. See the Utilization Management chapter for details. • Replacement or repair of a prosthetic device is payable once in a five-year period provided prior authorization has been obtained from the Utilization Management company. For precertification, see the Utilization Management chapter for details. • **Hearing Aid Benefit:** The Plan pays up to $500 per person every three years toward the purchase, servicing, fitting and/or repair of Medically Necessary external hearing aid devices. However, for Dependent Children with an audiology exam revealing bilateral hearing loss of 30 decibels or greater, the Plan allows an additional payment up to $1,500 per person every three years toward the purchase, servicing, fitting and/or repair of Medically Necessary hearing aid devices. • Coverage is provided under this Medical Plan for an implantable hearing device (such as a cochlear implant,) for children, when determined to be Medically Necessary by the Claims Administrator or its designee, that meets all of the following parameters: – Children 12 months of age or older with bilateral sensorineural hearing impairment with thresholds of 90 dB or greater at 1000 Hz; and limited benefit from appropriately-fitted binaural hearing aids. – Replacement speech processors and other external parts associated with implantable hearing devices for children are payable when determined to be Medically Necessary by the Claims Administrator or its designee because the existing device cannot be repaired or replacement is required because a change in the person's condition makes the present unit non-functional and improvement is expected with a replacement unit. • See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter.	90% after deductible met	50%after deductible met	90% after deductible met	50% after deductible met
DENTAL SERVICES		Not Covered See also the Dental Plan chapter.	Not Covered See also the Dental Plan chapter.	Not Covered See also the Dental Plan chapter.	Not Covered See also the Dental Plan chapter.
DIALYSIS • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Covered when order by a Physician. • **It is required that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
DIETARY SERVICES • Benefits are payable for nutritional counseling to assist individuals with their nutritional health and dietary needs. Services can be used for assistance with food choices when diagnosed with such diseases as obesity, high blood pressure, cardiac disease, diabetes, high cholesterol, allergies, kidney disease, etc. • Services are payable only when performed by a Registered Dietician or licensed or certified Nutritionist.	• Services of a Registered Dietician or licensed or certified Nutritionist are payable to a maximum of 5 visits per person per calendar year. This visit limit does not apply to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health or substance abuse condition. • As a preventive counseling benefit in compliance with Health Reform, the Plan covers the following services: For adults (1) with a body mass index of 30 kg/m^2 or higher, OR (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m^2) or obese (defined as a BMI of 30 kg/m^2 or higher) AND have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed **intensive behavioral counseling** interventions. Intensive behavioral counseling interventions means the Plan will consider as medically necessary preventive services, up to a combined limit of 26 individual or group visits per 12-month period by an in-network provider. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician. • This dietary counseling is payable as a Wellness service in accordance with Health Reform requirements.	100% no deductible	No coverage	100% no deductible	No coverage

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
DRUGS (Outpatient Prescription Medicines) • Coverage is provided for those pharmaceuticals (drugs & medicines) approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner. Drugs required to be covered by Health Reform law are also covered. • Coverage is also provided for FDA approved contraceptives such as birth control products/pills, and injectable contraceptives like Depo-Provera; Insulin and diabetic supplies such as lancets, insulin syringes, alcohol swabs, blood and urine testing agents and strips; Glucagon, bee sting kits. • Contact the Prescription Drug Program (the phone number is listed on the Quick Reference Chart in the front of this document) for the following: a. Drugs on the **Preferred Drug formulary**. b. **Certain drugs need Preapproval** by the clinical staff of the Prescription Drug Program to avoid non-payment, such as injectables, attention deficit disorder medications, erectile dysfunction medication for BPH, growth hormone, Retin A, proton pump inhibitors (PPIs) to treat stomach ulcers and gastroesophageal reflux disease, proprotein convertase subtilisin kexin 9 (PCSK9) inhibitors, and non-sedating antihistamines (NSAH). Coverage for prescription NSAHs is payable only when treatment with Claritin has failed or treatment is for pet dander allergies. Other medications included in the Clinical Programs of the Prescription Drug Provider such as Specialty Drugs may also require preapproval. **There will be no coverage for any of these medications unless preapproved**. c. Drugs that have a **limit to the quantity payable** by the Plan such as certain medication for pain, fungus, sleeping, migraine and asthma. Erectile dysfunction drugs (e.g. Viagra, Cialis, Muse, Caverject) payable up to 6 doses per month; when preapproved, a daily dose is payable for treatment of benign prostatic hypertrophy (BPH). d. Information on which drugs are part of the **Step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug treatment option. For example, currently these drugs or classes of drugs require step therapy: Lyrica, nasal sprays, beta blockers, sleep medication, Cox-2 anti-inflammatory drugs and drugs to treat elevated blood pressure (ARBs), osteoporosis, depression, overactive bladder, statins for elevated cholesterol, and migraines. e. **Specialty Drugs** are available on an outpatient basis only when ordered through, **precertified** and managed by the Prescription Drug Program. Specialty drugs are products derived from living organisms used by individuals with unique health concerns and include items such as injectables and infusibles for multiple sclerosis, cancer or hepatitis. These drugs often require special handling, are date sensitive and are usually available only in a 30-day quantity.	• Your best price for prescriptions are those provided through the Plan's contracted Prescription Drug Program, whose name is listed on the Quick Reference Chart in the Introduction chapter of this document. This Prescription Drug Program pays for generic drugs, unless a generic is not available. If you choose to have your prescription filled with a brand name drug when a generic drug is available, you will pay the copay and coinsurance noted to the right plus the difference in cost between the brand and generic drug. If no generic drug is available the Plan will pay for a brand name drug. • **Retail Drugs**: To obtain a 34-day supply of medication for the cost-sharing noted to the right, present your ID card to any in-network retail pharmacy. You can find the location of in-network retail pharmacies by contacting the Prescription Drug Program whose name is listed on the Quick Reference Chart in the front of this section of the handbook. • **Mail Order (Home Delivery) Service:** The mail order service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. To use the mail order service, have your physician write the prescription for a 90-day supply, with the appropriate refills. Mail your prescription, copay and the mail order form to the Mail Order Services of the Prescription Drug Program. Mail order forms may be obtained from the customer service or website of the Prescription Drug Program. Allow up to 14 days to receive your order. • Copayments for Mail Order drugs are not applied to the Plan's Deductibles. • Growth hormone medication requires precertification and is payable only when Medically Necessary for individuals with documented growth hormone deficiency or, cachexia (a severe muscle, fat and weight loss syndrome) not remedied by other means, as determined by the professionals of the Prescription Drug Program. • Certain classes of drugs are not payable under this Plan such as drugs for treatment of obesity, cosmetic drugs, and fertility/infertility. See the exclusions related to Drugs (Medicines) in the Exclusions chapter for details on non-covered drugs. • **Tobacco/smoking cessation benefit**: Coverage is extended for FDA-approved tobacco cessation products (such as nicotine gum or patches) intended to assist an individual to stop smoking or using tobacco products**.** Present a written prescription from a physician for tobacco cessation products to the retail pharmacist. This benefit is not available through the plan's mail order program. See also the Behavioral Health row for counseling support. See the Smoking/Tobacco Cessation Program row for more information. • New drugs that have not yet been approved by the FDA are **not** covered. New FDA-approved drugs will be covered by the Plan if the class of drugs is a covered benefit of the Plan. • **Influenza vaccine (flu shot) and shingles vaccine** administered at a retail pharmacy is payable at no charge. In accordance with Health Reform, certain **over-the-counter (OTC) and prescription drugs** are payable at no charge when prescribed by a Physician or Health Care Practitioner. For details, see the OTC section in Chapter 4 "Medical Plan Options" or call the Prescription Drug Program. • **No charge for generic maintenance medication obtained at Mail Order.** Also, certain Health Reform mandated drugs are payable at no charge. Contact the Prescription Drug Program for the list of maintenance medications and Health Reform mandated drugs available at no charge. Certain generic and brand name **preventive medications are payable at 100%,** no deductible when obtained at Retail or Mail Order. Contact the Prescription Drug Program for the list of preventive medications available at no charge. • When you take certain Specialty Drugs, such as to treat hepatitis, arthritis or multiple sclerosis, the drug manufacturer may offer a **manufacturer sponsored coupon** that together with the cost-sharing under the Medical plan may help lower the cost of the drug to you. The Plan participates in the **High Impact Advocacy Program**, administered by the Prescription Drug Program, to help manage the cost of selected specialty medications to reduce or eliminate your out-of-pocket expenses. Contact the Prescription Drug Program (listed on the Quick Reference Chart) for more information. • For convenience, the Plan permits you to obtain a 90-day supply of drugs at an in-network retail pharmacy location and you will pay three (3) times the normal monthly retail cost-sharing amount. The Plan permits coverage of female contraceptives prescribed by a pharmacist who is acting within the scope of his/her state license.	**Annual Prescription Drug Deductible:** (for drugs purchased through retail or mail order) **$75 per individual; $150 per family.** For these plan options, the retail pharmacy, mail order pharmacy and specialty drug coinsurance will accumulate to a **separate prescription drug Out-of-Pocket Maximum on Coinsurance of $1,000/individual and $2,000/family per calendar year**, thereafter the Plan pays 100%. Deductible and copays do not accumulate to this Out-of-Pocket Maximum on Coinsurance. Cost-sharing for drugs does accumulate to the Medical Plan Out-of-Pocket Limit. See also the Out-of-Pocket Limit row in this Schedule. After the deductible is met the Prescription Drug benefits are as follows: **Network Retail Pharmacy (34-day supply):** **Generic:** you pay 10% of the drug cost with a minimum of $5.00 (or the cost of the drug if less than $5.00). For Generic Contraceptives, the plan pays 100%, there's no copay/coinsurance or deductible. **Preferred Brand:** you pay 20% of the drug cost with a minimum of a $10.00 (or the cost of the drug if less than $10.00). You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available. **Non-Preferred Brand:** you pay 20% of the drug cost with a minimum of a $10.00 (or the cost of the drug if less than $10.00). You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available and the difference in cost if you choose a non-preferred brand when preferred brand drug is available. **No coverage for prescriptions filled at Wal-Mart, or at Sam's Club Retail or Mail Order locations.** **Specialty Drug Program:** All specialty drug claims require prior approval and are limited to a 30-day supply. The copays that apply to specialty drugs depend on whether the drug is a retail claim or a mail order claim. **Mail Order Service (90-day supply):** **Generic:** you pay a $10 copay. For Generic Contraceptives and generic drugs used for maintenance purposes, the plan pays 100%, there's no copay/coinsurance or deductible. Contact the Prescription Drug Program for the list of permitted maintenance drugs. **Preferred Brand:** you pay a $20 copay. You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available. **Non-Preferred Brand:** you pay a $40 copay. You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available. **Use of Out-of-Network Retail Pharmacy:** If you fill a prescription at an out-of-network retail pharmacy, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the address of the Prescription Drug Program using the Direct Member Reimbursement (DMR) process as listed on the Quick Reference Chart. For eligible prescriptions, you pay 40% of the cost of the drug.			

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
DURABLE MEDICAL EQUIPMENT (DME) • Coverage is provided for: – **rental** (but only up to the allowed purchase price of the Durable Medical Equipment); – **purchase of standard models** at the option of the Plan; – **repair, adjustment, servicing or Medically Necessary replacement** of the DME due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired. Replacement of DME is payable once every five years only if the equipment cannot be adequately repaired at a lesser expense. • Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.	• **Continuous Positive Airway Pressure (CPAP) devices require precertification**. See the Utilization Management chapter of this document. • See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter. To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. • Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner. • For assistance in determining if proposed equipment will be payable as Durable Medical Equipment (DME) under this Plan, please contact the Claims Administrator at their contact information listed on the Quick Reference Chart in the front of this document. • While breastfeeding, coverage is provided for one standard manual or standard electric breast pump, plus necessary supplies to operate the breast pump. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from in-network providers only. No coverage out-of-network.	**Breast pump and supplies:** 100%, no deductible **All other DME:** 90% after deductible met	**Breast pump and supplies:** Not covered. **All other DME:** 50% after deductible met	**Breast pump and supplies:** 100%, no deductible **All other DME:** 90% after deductible met	**Breast pump and supplies:** Not covered. **All other DME:** 50% after deductible met
EMERGENCY ROOM (ER) & URGENT CARE FACILITY SERVICES • Hospital emergency room (ER) for a medical Emergency including emergency services as that term is defined in this document. • Use of an Urgent Care facility. • Ancillary charges (such as lab or x-ray) performed **during** the ER or Urgent care visit. • (See also the Ambulance section of this schedule.)	• If an Emergency room service is subject to a copayment per visit, the copay will be waived if subsequent immediate Hospitalization is required. • Out-of-network emergency room services are payable at the in-network level of benefits only if the treatment is for an emergency, as defined by the Plan in the Definitions chapter of this document under the heading of "Emergency Care." • If a participant is treated at an In-network ER and a treating physician is an out-of-network provider, claims are paid at the in-network level of benefits up to the Allowed Charges, as that term is defined in this Plan. • There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. Also, the Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with health reform Affordable Care Act regulations. See the definition of Allowed Charge or contact the medical plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers.	**Emergency Room and physician fees associated with care in the ER:** You pay a $100 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses. **Urgent Care Facility:** You pay a $50 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses.	**Emergency Room and physician fees associated with care in the ER:** You pay a $100 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses. **Urgent Care Facility:** 50%after deductible met	**Emergency Room and physician fees associated with care in the ER:** You pay a $100 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses. **Urgent Care Facility:** You pay a $50 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses.	**Emergency Room and physician fees associated with care in the ER:** You pay a $100 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses. **Urgent Care Facility:** 50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network

ENTERAL THERAPY SERVICES
• Enteral nutritional therapy provides nourishment directly to the digestive tract of a person who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutritional formula is payable when medically necessary and all the following criteria are met:
  • When the formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and ALL of the following criteria are met:
  • Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements, and
  • The individual has one of the following conditions that is expected to be permanent or of indefinite duration:
  • an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel;
  • disease of the small bowel that impairs absorption of an oral diet;
  • a central nervous; or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.
	• Enteral therapy services are covered only when ordered by a Physician.
	• Coverage for a home enteral infusion pump (and associated necessary supplies) is considered payable when the use of the pump is medically necessary because the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion of the enteral formula.
	• Enteral nutritional formula that is not payable by the plan includes:
	  • standardized or specialized infant formula or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems.
	  • food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like.
	  • weight-loss foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and mineral.
		90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

FAMILY PLANNING AND CONTRACEPTIVE SERVICES • Sterilization services (e.g., vasectomy, tubal ligation, Essure). • FDA approved contraceptives including oral birth control pills/patches, injectables (e.g., Depo-Provera), Intrauterine devices (IUD), diaphragms, implantable birth control devices.	• See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Sexual Dysfunction Services in the Exclusions chapter. • No coverage for the diagnosis or treatment of fertility and infertility. • No coverage for the diagnosis or surgical treatment of sexual dysfunction. Coverage is provided for erectile dysfunction medications under the Outpatient Prescription Drug Benefit (e.g., Viagra, Cialis, Levitra, Muse, Caverject) to a maximum of 6 doses per person per month. • No coverage for reversal of sterilization procedures.	90% after deductible met FDA approved Contraceptive Methods and counseling, and Sterilization: 100%, no deductible.	50% after deductible met	90% after deductible met FDA approved Contraceptive Methods and counseling, and Sterilization: 100%, no deductible.	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
GENETIC TESTING AND COUNSELING The genetic testing payable under this Plan is for: a. state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers); b. genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see the Preventive Services row in this Schedule). c. fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee; d. tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; e. the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants who have <u>all</u> the following: • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; <u>and</u> • the covered individual displays clinical features/symptoms, or is at direct risk of developing the genetically linked heritable disease/condition in question (pre-symptomatic); <u>and</u> • the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being delivered to the covered individual in conjunction with a genetic test that is payable by this Plan.	• **Genetic testing noted in "c", "d" and "e" to the left, must be precertified.** See the Utilization Management chapter of this document. • Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided with regard to a genetic test that is payable by this Plan. • Certain genetic testing is payable at no cost to you. See the Preventive Services row in this Schedule. • See also the definitions of Genetic Counseling and Genetic Testing in the Definitions chapter. • No coverage for pre-parental genetic testing or any other genetic testing and counseling not related to the benefits outlined to the left. See also the Exclusions chapter for exclusions relating to Genetic Testing and Counseling.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
HEARING BENEFITS	• See the Corrective Appliance row of this schedule.				
HOME HEALTH CARE AND HOME INFUSION SERVICES • Part-time, intermittent **Skilled Nursing Care** services and Medically Necessary supplies to provide Home Health Care or home infusion services, subject to an Annual Maximum Plan Benefit shown in the Explanations and Limitations column.	• **Home health and home infusion therapy services require precertification.** See the Utilization Management chapter of this document. • See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions chapter of this document. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner. • The Annual Maximum Benefit for Skilled Nursing Care services and supplies to provide Home Health Care, Home Infusion Services and home health aide services is **100 visits** per person per calendar year. • Home Hospice coverage is described below under Hospice benefits. Home Physical Therapy services coverage is described below under Rehabilitation Services benefits. Prescription Drugs (Medicines) coverage is described above under Drugs (Medicines) benefits.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met
HOSPICE • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the definition of hospice in the Definitions chapter of this document.	• **Inpatient hospice admission require precertification.** See the Utilization Management chapter of this document. • Bereavement counseling beyond that included as part of the Hospice program is payable under the Behavioral Health benefits of this Plan. • **Respite Care:** The Plan covers up to 8 days of Respite care during a Hospice benefit. Respite care may include expenses for medical services and supplies when confined in a facility maintained by a hospice agency when such confinement is for respite care to relieve the person residing with and caring for the terminally ill patient in his/her home.	90% after deductible met	Home Hospice: 50% after deductible met. Inpatient Hospice: Not covered.	90% after deductible met	Home Hospice: 50% after deductible met. Inpatient Hospice: Not covered.
LABORATORY SERVICES (Outpatient) • Technical and professional fees.	• **Sleep studies (called polysomnography) and certain genetic testing (see the genetic testing row) require precertification.** See the Utilization Management chapter of this document. • Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Certain lab testing is payable at no cost to you. See the Preventive Services row in this Schedule.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
MATERNITY SERVICES • Hospital and Birth (Birthing) Center charges and Physician and Midwife fees for Medically Necessary maternity services. • One routine ultrasound per pregnancy is payable. • Termination of pregnancy is covered only when the attending Physician certifies that the female Employee or Spouse's health would be endangered if the fetus were carried to term or where complications arise from an abortion. • See Genetic Testing for additional information. • The Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a qualified provider, while breastfeeding, at 100%, no deductible for all females, when provided by an in-network provider. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.	• **Prenatal and postnatal office visits, breast pump and supplies, lactation counseling and Health Reform –mandated preventive services are payable for all females with no cost-sharing when performed by an in-network provider**. • Pregnancy-related care is covered for a female Employee or Spouse only. For an employee or spouse, normal plan cost-sharing applies to all other maternity related services including an ultrasound and delivery fees. • Expenses related to a complication of a pregnancy of a Dependent Child are payable at normal cost-sharing. **No coverage is provided for delivery-related expenses of a pregnant dependent child and their newborn**. • Certain prenatal care and preventive expenses for pregnant women (as listed on the government website at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to screening for gestational diabetes, breastfeeding supplies, rental of breast feeding equipment and, comprehensive lactation support and counseling by a trained provider while breastfeeding are covered under the Wellness/Preventive Services category without cost sharing from in-network providers for a female Employee, Spouse and Dependent Child. • See the exclusions related to Maternity Services in the Exclusions chapter. • See also, the Special Rule for Coverage of Newborn Dependent Children in the Eligibility chapter. • **Hospital Length of Stay for Childbirth:** The Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).	**Prenatal and postnatal office visits and Health Reform mandated preventive care:** 100%, no deductible. Breastfeeding equipment and supplies: See the DME row. **Breastfeeding Lactation counseling:** 100%, no deductible **All other maternity services for an Employee or Spouse including an ultrasound and professional delivery fees:** 90% after deductible met **For a pregnant dependent child** you pay 100% for certain prenatal tests like ultrasounds and delivery expenses.	**For an Employee or Spouse:** 50% after deductible met **For a pregnant dependent child** the Plan does not pay, and instead you pay expenses beyond office visits and Health Reform mandated preventive services, meaning you pay for services such as ultrasounds and delivery expenses.	**Prenatal and postnatal office visits and Health Reform mandated preventive care:** 100%, no deductible. Breastfeeding equipment and supplies: See the DME row. **Breastfeeding Lactation counseling:** 100%, no deductible **All other maternity services for an Employee or Spouse including an ultrasound and professional delivery fees:** 90% after deductible met **For a pregnant dependent child** you pay 100% for certain prenatal tests like ultrasounds and delivery expenses.	**For an Employee or Spouse:** 50% after deductible met **For a pregnant dependent child** the Plan does not pay, and instead you pay expenses beyond office visits and Health Reform mandated preventive services, meaning you pay for services such as ultrasounds and delivery expenses.

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
NONDURABLE SUPPLIES Coverage is provided for: • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. • Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under the Prescription Drug Program.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
ORAL, CRANIOFACIAL, AND TMJ SERVICES • Accidental Injury to Teeth. • Temporomandibular Joint (TMJ) dysfunction or syndrome. • Oral and/or Craniofacial Surgery. • Oral Surgery only for services noted to the right.	• See the Dental Services exclusions in the Exclusions chapter. • **Alveolar ridge reconstruction** is payable including the use of hydroxylapatite particles and inserts for augmentation of mandibular and maxillary alveolar ridges provided the Claims Administrator receives documentation of treatment for ulceration, appropriate dental x-rays and documentation that the patient has been wearing dentures for at least 10 years. • **Treatment of Accidental Injuries to the Teeth:** The Plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met: – The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and – The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and – The dental treatment will return the person's teeth to their pre-injury level of health and function. See the definition of Injury to Teeth in the Definitions chapter of this document. • **Treatment of Temporomandibular Joint (TMJ) dysfunction or syndrome is payable only if preauthorized** through the Utilization Management Company. See the Utilization Management chapter of this document. **Medically necessary surgery for TMJ syndrome/dysfunction is payable to a maximum of $5,000 per person per lifetime.** • **Oral or craniofacial surgery** is limited to cutting procedures to remove tumors/cysts. No coverage for dental services such as removal of wisdom teeth, extraction of boney impacted teeth, root canal, gingivectomy, or dental abscess treatment. • Coverage is provided by the Plan for up to $10,000 per person per calendar year to a maximum of $25,000 per person per lifetime for eligible dental services resulting from Medically Necessary **orthognathic surgery**. Coverage is payable for orthognathic surgery for the treatment of prognathism, retrognathism and other reasons if determined by the Plan Administrator or its designee to be Medically Necessary and not cosmetic.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met
OUTPATIENT (Ambulatory) SURGERY • Ambulatory (Outpatient) Surgical Facility or Center. • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• **Admission to an outpatient surgical facility requires precertification.** See the Utilization Management chapter for details. • Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services if the utilization management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this medical plan.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
PREADMISSION TESTING (Outpatient) • Laboratory tests, x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.	• Covered only when ordered by a Physician or Health Care Practitioner.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met
RADIOLOGY (X-Ray), NUCLEAR MEDICINE AND RADIATION THERAPY SERVICES (Outpatient) • Technical and professional fees associated with diagnostic and curative services, including radiation therapy. • One routine ultrasound per pregnancy.	• **The following tests and diagnostic procedures require precertification: Magnetic Resonance Imaging (MRI) scan, CT scan, Endoscopy, and Colonoscopy.** See the Utilization Management chapter of this document. • Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered under the Preventive Services Programs described in the Wellness row of this Schedule.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met
RECONSTRUCTIVE SERVICES AND BREAST RECONSTRUCTION AFTER MASTECTOMY • The Plan complies with the **Women's Health and Cancer Rights Act** 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.	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter. Most Cosmetic services are excluded from coverage. • Reconstructive Surgery is payable if such procedures or treatment are necessary for the repair or alleviation of damage resulting from a disability caused by accidental bodily injuries sustained by a Participant, trauma, infection or disease of the involved part or the surgery is necessary because of congenital disease or anomaly of a Dependent Child which has sustained a functional defect.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
REHABILITATION SERVICES (Cardiac and Pulmonary) • **Cardiac Rehabilitation** is available to individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.). • **Pulmonary Rehabilitation** is available to individuals who are able to actively participate in a Pulmonary Rehabilitation program that is likely to improve their pulmonary condition, as determined by the Plan Administrator or its designee.	• **Cardiac rehabilitation services require precertification**. See the Utilization Management chapter of this document. • Cardiac and Pulmonary Rehabilitation programs must be ordered by a Physician. • See also the Definition of Cardiac Rehabilitation in the Definitions chapter of this document.	90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met
REHABILITATION SERVICES (Occupational, Physical, & Speech Therapy) • Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.**	• **Physical and occupational therapy after three initial visits requires precertification. Inpatient rehabilitation admission requires precertification**. See the Utilization Management chapter for details. • Maintenance Rehabilitation, habilitation, and coma stimulation services are not covered. See exclusions relating to Rehabilitation Therapies in the Exclusions chapter. • Rehabilitation services are covered only when ordered by a Physician. • **Speech therapy which is to last beyond two (2) months must be precertified through the Utilization Management firm.** See the Utilization Management chapter of this document. • **Speech therapy** is covered if provided by a licensed or duly qualified speech therapist to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Speech therapy for functional purposes, (including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin) or childhood developmental speech delays and disorders are excluded from coverage.	90% after deductible met	Inpatient rehabilitation admission: No coverage. All other rehabilitation services: 50% after deductible met	90% after deductible met	Inpatient rehabilitation admission: No coverage. All other rehabilitation services: 50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
ROUTINE COSTS RELATED TO CLINICAL TRIALS • Routine patient costs for all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. • The Clinical Trial must be approved as a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition as more fully described by law. A life threatening condition is any disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.	• **Clinical Trial Participation is subject to precertification for the purpose of (i) determining whether you are a "qualified individual", (ii) to verify that the trial is an "approved clinical trial" within the meaning of the law and (iii) to determine whether there exists an in-network clinical trial that will accept you as a participant.** • A "qualified individual" must be eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition and either: (i) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or (ii) the individual provides medical or scientific information establishing that the individual's participation in such trial would be appropriate based upon the above conditions. • The level of Plan coverage of routine costs will be based on whether the items or services are provided through in-network or out-of network providers. If one or more in-network providers is participating in a clinical trial the Plan requires that a qualified individual participate in the in-network provider's clinical trial if the participating provider will accept the individual as a participant in the trial. • "Routine patient costs" do not include (i) the investigational item, device or service itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	**Routine Costs Related to your Clinical Trial Participation** Coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan.	**Routine Costs Related to your Clinical Trial Participation** Coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan.	**Routine Costs Related to your Clinical Trial Participation** Coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan.	**Routine Costs Related to your Clinical Trial Participation** Coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan.
SKILLED NURSING FACILITY (SNF) OR SUBACUTE FACILITY • Skilled Nursing Facility (SNF). • Subacute Care Facility.	• Services must be ordered by a Physician. To determine if a facility is a skilled nursing or subacute facility see the Definitions chapter of this document. • **Admission to a Skilled Nursing Facility confinement or Subacute care facility confinement requires precertification.** See the Utilization Management chapter for details. • **Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to 120 days per calendar year.**	90% after deductible met	No coverage.	90% after deductible met	No coverage.

SMOKING/TOBACCO CESSATION PROGRAMS
• This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco). This benefit includes:
  • Acupuncture as a treatment for tobacco cessation.
  • Low level laser therapy as a treatment for tobacco cessation.
	• Coverage is extended for programs intended to assist an individual to stop smoking or using tobacco products. This coverage includes these tobacco cessation treatment options: low level laser therapy or acupuncture. No coverage for hypnosis or massage therapy.
	• Claims for over-the-counter and prescription tobacco cessation products are able to be reimbursed by the Plan at 100% with a prescription. See the Drug row of this Schedule of Medical Benefits for information on coverage of drugs to help with tobacco cessation.
	• See the Behavioral Health Services row for information on counseling that can be used to treat a nicotine addiction.
		90% after deductible met	50% after deductible met	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
TRANSPLANTS (Organ and Tissue) • Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue and **only for the following:** heart, kidney, cornea, bone marrow, lung, liver, heart/lung, pancreas and kidney/pancreas, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Coverage includes: – charges for the live donor for removal of a donated organ/tissue for a preauthorized transplant to a Participant or, – for a Participant who is a live donor, for removal of a donated organ when the organ is one which would have been covered if the recipient were a Participant and when the recipient's insurance specifically excludes coverage for charges incurred by a donor; or – Cadaver donor expenses. • No coverage for expenses incurred by a person who donates an organ or tissue, unless the person who receives the donated organ/tissue is the person covered by the Plan.	• See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter. • **Transplant services (including pre-transplant workup tests) are subject to precertification.** See the Utilization Management chapter for details. • Donor expenses are payable to a maximum of $20,000 per person per transplant. • **Out-of-Network Transplant Maximums:** The Plan pays up to the maximums noted below: – Heart: $110,000 including a max of $20,000 for physician services. – Lung: $155,000 including a max of $20,000 for physician services. – Bone Marrow: $130,000 including a max of $20,000 for physician services. – Liver: $130,000 including a max of $20,000 for physician services – Heart/Lung: $150,000 including a max of $20,000 for physician services. – Pancreas: $70,000 including a max of $20,000 for physician services. – Kidney: $55,000 including a max of $20,000 for physician services. – Kidney/Pancreas: $95,000 including a max of $20,000 for physician services. • **Transplant Related Travel Benefit:** The Plan benefit for transplant related travel expenses, including transportation, lodging for the patient and one family member or companion is $10,000 per transplant. Reimbursement is available for round trip "coach" airfare, and up to a maximum of $200 per day for lodging received during the pre-operative work-up, transplant operation and post-transplant treatment phases. Receipts are required when submitting lodging, and travel expenses for payment consideration. The IRS allows $50 per day to be received on a tax free basis. Any amounts in excess of $50.00 per day will be treated as taxable income to the employee and the Plan Administrator will be responsible for preparing a 1099 to report that income. – The following expenses will not be reimbursed by the Plan: meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and expenses for persons other than the patient and his/her designated family member/travel companion.	90% after deductible met	50% after deductible met up to the maximum noted to the left under Explanations	90% after deductible met	50% after deductible met up to the maximum noted to the left under Explanations
VISION SERVICES		See the chapter on the Vision Plan.	See the chapter on the Vision Plan.	See the chapter on the Vision Plan.	See the chapter on the Vision Plan.

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

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Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
WELLNESS - PREVENTIVE SERVICES PROGRAM: WELL CHILD EXAMINATIONS AND IMMUNIZATIONS • Outpatient newborn and well child visits and **routine childhood immunizations** that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"), including flu shots. • Wellness and preventive services are payable as listed on the websites shown in the column to the right. • In this section and the following section on Preventive Services the term "cost-sharing" is used to refer to costs you would pay under the Plan, such as deductibles, coinsurance and copayments. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • For children age 6 years and older with obesity, Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • Performed in primary practices, **topical fluoride** varnish to the primary teeth of children through age 5 years. • If the Plan does not have in its network a provider who can provide a particular required preventive service, then the Plan will cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.	The preventive services payable by this plan (without cost-sharing on your part) are designed to comply with Health Reform regulations. With respect to infants, children and adolescents, evidence-informed preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) are covered as well as immunizations for routine use in children, and adolescents that are recommended by the Advisory Committee on Immunization Practices (ACIP). For complete and up-to-date information see https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. In addition to the wellness/preventive services listed on the websites here, the Plan will pay for well child office visits. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services. • When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance and deductible) will apply to the diagnostic or therapeutic services provided. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. Services not covered under the Preventive Services wellness benefit may be covered under another portion of the medical plan. • If your in-network health care provider prescribes a vaccine consistent with the ACIP recommendations, the Plan will provide coverage without cost-sharing. New ACIP recommendations will be covered without cost-sharing starting with the Plan year that begins on or after the date that is one year after the date the recommendation is issued. • See the Special Rule for Coverage of Newborn Dependent Children in the Eligibility chapter. • See the exclusion of expenses for physical examinations and testing required for school, camp, recreation, sports, etc., in the Exclusions chapter.	100%, no deductible	50% after deductible met	100%, no deductible	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE PREMIUM HEALTH PLAN AND PREMIUM PLUS PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Premium Health Plan		Premium Plus Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network
WELLNESS - PREVENTIVE SERVICES PROGRAM: ADULT HEALTH MAINTENANCE EXAMINATIONS (for Active Employees, their Spouse and Dependent Children as appropriate) including: • Complete history and physical examination; x-ray charges for chest x-ray; routine screening mammogram; annual gynecology exam for purpose of obtaining a pap smear; laboratory charges for complete blood count, urinalysis, pap smear, and prostate blood test (PSA); screening colonoscopy; CDC-recommended immunizations including flu shots. See also Well Child Examinations and Immunizations . • Preventive Services consist of 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 ("USPSTF") with respect to the individual involved. Preventive Services also includes immunizations for routine use in adults that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"). • With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") to the extent not already included in certain recommendations of the USPSTF. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • If any recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a service, the Plan will use reasonable medical management techniques to determine any coverage limitations. • The Plan recognizes that certain USPSTF recommendations apply to certain individuals identified as "high-risk" due to factors such as family or personal history of disease. Therefore, if the attending provider determines that a patient belongs to a high-risk population and a USPSTF recommendation applies to that high-risk population, any preventive item or service recommended by the USPSTF in connection with such high-risk individual will be covered without cost-sharing subject to reasonable medical management. • If the Plan does not have in its network a provider who can provide a particular required preventive service, then the Plan will cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.	The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). These websites list the types of payable preventive services (such as immunizations, mammogram, pap smear, and screening colonoscopy): https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. In addition to the Preventive Services listed on the website above, the Plan will pay for these Preventive Services: an annual (although in some circumstances several visits may be necessary depending on health factors) wellness/physical exam for adults, annual prostatic specific antigen (PSA) lab test for men, screening mammogram for women at any age, chest x-ray, EKG. complete blood count and urinalysis. A screening colonoscopy (including anesthesia) is payable for participants age 50 years and older once every five years. • For people with certain health conditions, over-the-counter ("OTC") medications may be recommended by their health care provider, When OTC medications are recommended by the USPSTF and prescribed by your health care provider the Plan will cover such OTC medications without cost-sharing. Contraceptive methods must be FDA-approved and prescribed for a woman by her health care provider. The HRSA guidelines do not include contraception for men. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. Under certain circumstances as stated in regulatory guidance, some procedures, such as polyp removal during a screening colonoscopy are considered an "integral part" of the preventive service. In these circumstances the Plan will not impose cost- sharing on you. However, the Plan will impose cost- sharing for a treatment that is not a recommended preventive service even if the treatment results from a recommended preventive service. • For women's preventive services, genetic counseling and an evaluation for routine breast cancer susceptibility gene (BRCA) may include without cost-sharing the BRCA test itself, if appropriate, as determined by your health care provider. • **Women's Preventive Services:** HRSA Guidelines recommend at least one annual well-woman preventive care visit for adult women to obtain the recommended preventive services without cost-sharing that are age and developmentally appropriate including preconception and prenatal care. Additional preventive care visits (without cost-sharing but subject to reasonable medical management) may be necessary depending on a woman's health status, health needs and other risk factors as determined by the clinician .HRSA guidelines recommend annual HIV counseling and screening (which includes testing) for sexually active adult women and high-risk HPV DNA testing every three years for women as age and risk appropriate. HRSA Guidelines ensure women's access to the full range of FDA-approved contraceptive methods. However, the Plan will impose cost-sharing for brand name contraceptive drugs or other pharmacy products when a generic drug is available subject to medical appropriateness as determined by the individual's health care provider. Services related to follow-up and management of contraceptive side effects, counseling for continued adherence and device removal are covered without cost-sharing and subject to reasonable medical management. Comprehensive prenatal and postnatal lactation support, breastfeeding counseling and lactation equipment rental or, if appropriate, purchase, are covered for the duration of breastfeeding without cost-sharing and subject to reasonable medical management. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency and method to the extent not specified in a recommendation or guideline. Services not covered under the wellness benefit may be covered under another portion of the medical plan. • If your in-network health care provider prescribes a vaccine consistent with the Advisory Committee on Immunization Practices (ACIP) recommendations, the Plan will provide coverage without cost-sharing. New ACIP recommendations will be covered without cost-sharing starting with the Plan year that begins on or after the date that is one year after the date the recommendation is issued.	100% no deductible	50% after deductible met	100% no deductible	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
DEDUCTIBLE • Is the amount you must pay each calendar year before the Plan pays benefits. • Deductibles under this Plan are accumulated on a Calendar Year basis.	• Note that services from In-Network and Out-of-Network providers are combined to meet your annual deductible amounts. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are received by the Plan. • The amount applied to the deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan.	$300/person $900/family	$600/person $1,800/family
OUT-OF-POCKET MAXIMUM ON COINSURANCE • This Out-of-Pocket Maximum is the **maximum amount of coinsurance** you are responsible for paying each calendar year, in addition to the deductible and copays, **before** the Plan pays more of your eligible claims. Some out-of-pocket expenses do not apply to this maximum as described to the right. • A separate Out-of-Pocket Maximum does not apply to outpatient retail prescription drugs under this Comprehensive Health Plan. • **Note that services from In-Network and Out-of-Network providers are NOT combined to meet your annual Out-of-Pocket Maximum.**	The **Out-of-Pocket Maximum on Coinsurance** does not include or accumulate: a. Any plan **Deductible**. b. Any applicable **Copayments**. c. All expenses for medical services or supplies that are **not covered** by the Plan. d. All charges **in excess of the Allowed Charge** determined by the Plan. e. All charges **in excess of the Plan's Maximum Benefits**, or in excess of any other maximum or limitation of the Plan. f. Any additional other amounts you have to pay because you **failed to comply with the Utilization Management Programs** described in the Utilization Management chapter of this document. g. All expenses including copays and coinsurance for **Outpatient Prescription Drugs**. h. **Premiums and contributions** for coverage. i. **Dental Plan and Vision Plan** expenses. j. Expenses for a **non-network provider** (except that emergency services performed in a non-network emergency room will accumulate to the in-network out-of-pocket limit).	$2,000/person $4,000/family Once the maximum is reached the Plan pays 100% toward in-network providers.	No limit.

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
OUT-OF-POCKET LIMIT ON IN-NETWORK COST-SHARING • This Out-of-Pocket Limit is the **maximum amount of deductibles, copayment and coinsurance** you are responsible for paying each calendar year related to in-network essential health benefits, **before** the Plan pays the remainder of your eligible claims that year. • Some out-of-pocket expenses do not apply to this Out-of-Pocket Limit, as described to the right. • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person in a family" annual out-of-pocket limit.	• The Out-of-Pocket Limit is accumulated on a calendar year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Plan. • Effective January 1, 2015, covered outpatient prescription drugs accumulate to the in-network cost-sharing Out-of-Pocket Limit. • **The Out-of-Pocket Limit does not include or accumulate:** a. **Premiums and contributions** for coverage, b. Expenses for medical services or supplies that are **not covered** by the Plan, c. **Charges in excess of the Allowed Charge** determined by the Plan which includes balance billed amounts for non-network providers, d. **Penalties for non-compliance** with Utilization Management programs, e. Expenses for the **use of non-network providers**, except emergency services performed in an out-of-network Emergency Room will accumulate to the in-network Out-of-Pocket Limit, f. Charges **in excess of the Medical Plan's Maximum Benefits**, g. **Dental Plan and Vision Plan** expenses, h. Certain services or items with respect to which the Plan exercises its discretion to define as **not "Essential Health Benefits"** including but not limited to: 1) An individual's **out-of-pocket costs for a brand name prescription drug in circumstances in which** a generic was available and medically appropriate. The difference between the cost of the brand name drug and the cost of the generic drug will not be counted toward your Out of-Pocket Limit. In determining whether a generic is medically appropriate, the Plan will use a reasonable exception process, for example, the Plan may defer to the recommendation of an individual's personal physician, or it may offer an exceptions process meeting the requirements of 45 CFR 156.122(c). 2) Any service or item for which the **Plan imposes an annual maximum**, for example, acupuncture and chiropractic.	$6,600/person $6,600 per person in the family $13,200/family	No limit
HOSPITAL SERVICES (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms.	• **Inpatient hospitalization is subject to precertification**. All Hospitalization is subject to concurrent review. See the Utilization Management chapter for details. There is a $200 penalty for failure to precertify. • Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services if the Utilization Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or assistant dental provider fees under this medical plan. • See the Eligibility chapter for how to properly enroll Newborns so coverage can be considered.	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network

PHYSICIAN AND OTHER HEALTH CARE PRACTITIONER SERVICES
• Physician and Health Care Practitioner professional fees for services provided in a Hospital, Urgent Care Center, Health Care Facility, an office or at home, except as otherwise indicated in the Schedule of Medical Benefits.
• For payment of emergency services in an Emergency Room, see the Emergency Room row of this Schedule.
• Payable Physician and Health Care Practitioners include:
  • Surgeon;
  • Assistant surgeon (if Medically Necessary);
  • Anesthesia provided by Physicians, and/or Certified Registered Nurse Anesthetists (CRNA);
  • Pathologist; Radiologist;
  • Physician Assistant;
  • Nurse Practitioner; Nurse Midwife;
  • Podiatrist;
  • Breastfeeding/Lactation Educator (see the Maternity row for information).
	• **Some Physician and Health Care Practitioner services are subject to precertification. Certain tests require precertification, such as: Endoscopy and Colonoscopy.** See the Utilization Management chapter of this document for additional details.
	• **Primary Care Physician (PCP)** means a Physician or other Health Care Practitioner who practices general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology (OB/GYN). All other Physicians are considered specialists under this Plan.
	• The Plan Administrator or its designee will determine if multiple surgical or medical procedures will be covered as separate procedures or as a single procedure based on the definition of "Surgery" in the Definitions chapter.
	• Assistant Surgeons:
	– Physicians who act as an Assistant Surgeon will be reimbursed for Medically Necessary services to a maximum of **20%** of the eligible expenses payable to the primary surgeon.
	– All other health care practitioners who act as an Assistant Surgeon (e.g., physician assistant, nurse practitioner) will be reimbursed for Medically Necessary services to a maximum of **15%** of the eligible expenses payable to the primary surgeon. Certified Surgical Assistants (as defined by the Plan) are not payable.
	• See also "Prophylactic, Prophylactic Surgery" as defined in the Definitions chapter and the Prophylactic Surgery or Treatment Exclusions in the Exclusions chapter.
	• Coverage is provided for intravenous (IV) iron therapy when it is determined by the Plan to be Medically Necessary. **IV iron therapy requires precertification**. See the Utilization Management chapter for details on how to precertify.
	• Under this Plan, there is no requirement to select a Primary Care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
		Office Visit:
		Primary Care Physician (PCP):
		100% after a
		$25 copay per visit.
		No deductible.
		Specialist:
		100% after a
		$50 copay per visit.
		No deductible.
		All Other Services:
		90%
		after deductible
		met
			50%
			after deductible
			met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**			
Benefit Description	**Explanations and Limitations of Benefits**	**COMPREHENSIVE HEALTH PLAN**	
		In-Network	**Out-of-Network**
ACUPUNCTURE	• Payable to a maximum of $500 per person per calendar year if services are ordered by a Physician. This benefit limit does not apply to acupuncture used as a treatment for tobacco cessation. • Services are covered only if the HealthCare Practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided.	90% after deductible met	50% after deductible met
ALLERGY SERVICES • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician. Desensitization injections are covered only when provided by a licensed Health Care Practitioner.	Testing, Allergy Shots and Antigen: 90% after deductible met	Testing, Allergy Shots and Antigen: 50% after deductible met
AMBULANCE SERVICES • **Ground vehicle transportation** to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency, acute illness or inter-health care facility transfer. • **Air transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.	• Expenses for **ground vehicle ambulance services are covered only when those services are for an Emergency** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care." • Non-emergency medical transportation refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-emergency medical monitoring during transport. **Non-emergency medical transportation services are payable when precertified**.	90% after deductible met	90% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
BEHAVIORAL HEALTH SERVICES (Mental Health and Substance Abuse Treatment) • **EAP Services:** The Plan provides an EAP Program that offers up to **8 free counseling visits** to the EAP. Contact the EAP Program whose name is listed on the Quick Reference Chart. • **Behavioral Health Services:** – **Inpatient**: means hospitalization at a Behavioral Health Treatment Facility or hospital that provides an area dedicated to behavioral health treatment. Inpatient also includes an admission to an in-network residential treatment program (as the term is defined in the Definitions chapter). – **Outpatient**: means office visits. Other outpatient services include partial hospitalization and an intensive outpatient treatment program. – **Psychological (Psychiatric) Testing**. – **Chronic pain control and pain rehabilitation** payable as part of Behavioral Health Services. – **Applied Behavioral Analysis Therapy.** See the definitions chapter.	• **EAP Services:** The Plan provides an EAP Program. When you are enrolled in one of the medical plan options you and your Dependents are eligible to use the EAP services for information and/or free confidential counseling visits for a wide range of problems and illnesses including stress, depression, anxiety, work life services, etc. EAP benefits are provided through a contracted EAP Program whose name and phone number are listed on the Quick Reference Chart in the Introduction chapter of this document. • **Inpatient hospitalization and residential treatment program admission requires precertification** by calling the Behavioral Health Program whose phone number is listed on the Quick Reference Chart in the front of this document. • **Residential treatment program** is covered (from in-network providers only) for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. See the definition of Residential Treatment Program. **Precertification is required**. • See the specific exclusions related to Behavioral Health Services in the Exclusions chapter. • Benefits are payable for services of Behavioral Health Care Practitioners listed in the Definitions chapter. • Outpatient prescription drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. • You may use these Behavioral Health services for counseling assistance for tobacco addiction.	**EAP:** 100% No deductible. **Inpatient:** 90% after deductible met **Outpatient Office Visit:** 100% after a $25 copay per visit. No deductible. **All other services:** 90% after deductible met	**Residential Treatment Program:** No coverage. **All other services**: 50% after deductible met
BLOOD TRANSFUSIONS • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician and if blood is not replaced at the blood bank. • Expenses related to autologous blood donation (patient's own blood) are covered.	90% after deductible met	50% after deductible met
CHEMOTHERAPY • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.		90% after deductible met	50% after deductible met
CHIROPRACTIC SERVICES • Chiropractic services include office visits, x-rays and manipulations performed by a Chiropractor.	• Chiropractic services are payable to a maximum of $50 per visit not to exceed $500 per person per calendar year.	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
CORRECTIVE APPLIANCES (Prosthetic and Orthotic Devices, Other Than Dental) • Coverage is provided for Medically Necessary corrective appliances as follows: – rental (but only up to the allowed purchase price of the device). – purchase of standard models at the option of the Plan. – repair, adjustment or servicing of the device or replacement of the device due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. • Colostomy or ostomy (orthotic) supplies. • Hearing Aid. • Corrective shoes or supportive devices for the feet including orthotics are not payable unless they are an integral part of a lower body brace.	• **Prosthetic devices require precertification**. See the Utilization Management chapter for details. • Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner. • Replacement or repair of a prosthetic device is payable once in a five-year period provided prior authorization has been obtained from the Utilization Management company. For precertification, see the Utilization Management chapter for details. • **Hearing Aid Benefit:** The Plan pays up to $500 per person every three years toward the purchase, servicing, fitting and/or repair of Medically Necessary external hearing aid devices. However, for Dependent Children with an audiology exam revealing bilateral hearing loss of 30 decibels or greater, the Plan allows an additional payment up to $1,500 per person every three years toward the purchase, servicing, fitting and/or repair of Medically Necessary hearing aid devices. • Coverage is provided under this Medical Plan for an implantable hearing device (such as a cochlear implant,) for children, when determined to be Medically Necessary by the Claims Administrator or its designee, that meets all of the following parameters: – Children 12 months of age or older with bilateral sensorineural hearing impairment with thresholds of 90 dB or greater at 1000 Hz; and limited benefit from appropriately-fitted binaural hearing aids. – Replacement speech processors and other external parts associated with implantable hearing devices for children are payable when determined to be Medically Necessary by the Claims Administrator or its designee because the existing device cannot be repaired or replacement is required because a change in the person's condition makes the present unit non-functional and improvement is expected with a replacement unit. • See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter.	90% after deductible met	50% after deductible met
DENTAL SERVICES		Not Covered See also the Dental Plan chapter.	Not Covered See also the Dental Plan chapter.
DIALYSIS • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Covered when order by a Physician. • **It is required that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. • See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible.	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
DIETARY SERVICES • Benefits are payable for nutritional counseling to assist individuals with their nutritional health and dietary needs. Services can be used for assistance with food choices when diagnosed with such diseases as obesity, high blood pressure, cardiac disease, diabetes, high cholesterol, allergies, kidney disease, etc. • Services are payable only when performed by a Registered Dietician or licensed or certified Nutritionist.	• Services of a Registered Dietician or licensed or certified Nutritionist are payable to a maximum of 5 visits per person per calendar year. This visit limit does not apply to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health or substance abuse condition. • As a preventive counseling benefit in compliance with Health Reform, the Plan covers the following services: For adults (1) with a body mass index of 30 kg/m^2 or higher, OR (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m^2) or obese (defined as a BMI of 30 kg/m^2 or higher) AND have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed **intensive behavioral counseling** interventions. Intensive behavioral counseling interventions means the Plan will consider as medically necessary preventive services, up to a combined limit of 26 individual or group visits per 12-month period by an in-network provider. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician. • This dietary counseling is payable as a Wellness service in accordance with Health Reform requirements.	100%, no deductible.	No coverage.

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network

DRUGS (Outpatient Prescription Medicines)
• Coverage is provided only for those pharmaceuticals (drugs & medicines) approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner. Drugs required to be covered by Health Reform law are also covered.
• Coverage is also provided for FDA approved contraceptives such as birth control products/pills, and injectable contraceptives like Depo-Provera; Insulin and diabetic supplies such as lancets, insulin syringes, alcohol swabs, blood and urine testing agents and strips; Glucagon, bee sting kits.
• Contact the Prescription Drug Program (the phone number is listed on the Quick Reference Chart in the front of this document) for the following:
  • Drugs on the **Preferred Drug formulary**.
  • **Certain drugs need preapproval** by the clinical staff of the Prescription Drug Program to avoid non-payment, such as injectables, attention deficit disorder medications, erectile dysfunction medication for BPH, growth hormone, Retin A, proton pump inhibitors (PPIs) to treat stomach ulcers and gastroesophageal reflux disease, proprotein convertase subtilisin kexin 9 (PCSK9) inhibitors, and non-sedating antihistamines (NSAH). Coverage for prescription NSAHs is payable only when treatment with Claritin has failed or treatment is for pet dander allergies. Other medications included in the Clinical Programs of the Prescription Drug Provider such as Specialty Drugs may also require preapproval. **There will be no coverage for any of these medications unless preapproved**.
  • Drugs that have a **limit to the quantity payable** by the Plan such as certain medication for pain, fungus, sleeping, migraine and asthma. Erectile dysfunction drugs (e.g. Viagra, Cialis, Muse, Caverject) payable up to 6 doses per month; when preapproved, a daily dose is payable for treatment of benign prostatic hypertrophy (BPH).
  • Information on which drugs are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug treatment option. For example, currently these drugs or classes of drugs require step therapy: Lyrica, nasal sprays, beta blockers, sleep medication, Cox-2 anti-inflammatory drugs and drugs to treat elevated blood pressure (ARBs), osteoporosis, depression, overactive bladder, statins for elevated cholesterol, and migraines.
  • **Specialty Drugs** are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are products derived from living organisms used by individuals with unique health concerns and include items such as injectables and infusibles for multiple sclerosis, cancer or hepatitis. These **drugs need precertification** and are managed because they often require special handling, are date sensitive and are usually available only in a 30-day quantity.
	• Your best price for prescriptions are those provided through the Plan's contracted Prescription Drug Program, whose name is listed on the Quick Reference Chart in the Introduction chapter of this document. This Prescription Drug Program pays for generic drugs, unless a generic is not available. If you choose to have your prescription filled with a brand name drug when a generic drug is available, you will pay the copay and coinsurance noted to the right plus the difference in cost between the brand and generic drug. If no generic drug is available the Plan will pay for a brand name drug.
	• **Retail Drugs**: To obtain a 34-day supply of medication for the cost-sharing noted to the right, present your ID card to any in-network retail pharmacy. You can find the location of in-network retail pharmacies by contacting the Prescription Drug Program whose name is listed on the Quick Reference Chart in the front of this section of the handbook.
	• **Mail Order (Home Delivery) Service:** The mail order service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. To use the mail order service, have your physician write the prescription for a 90-day supply, with the appropriate refills. Mail your prescription, copay and the mail order form to the Mail Order Services of the Prescription Drug Program whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the customer service or website of the Prescription Drug Program. Allow up to 14 days to receive your order.
	• Copayments for Mail Order drugs are not applied to the Plan's Deductibles.
	• Growth hormone medication requires precertification and is payable only when Medically Necessary for individuals with documented growth hormone deficiency or, cachexia (a severe muscle, fat and weight loss syndrome) not remedied by other means, as determined by the professionals of the Prescription Drug Program.
	• Certain classes of drugs are not payable under this Plan such as drugs for treatment of obesity, cosmetic drugs, and fertility/infertility. See the exclusions related to Drugs (Medicines) in the Exclusions chapter for details on non-covered drugs.
	• **Tobacco/smoking cessation benefit**: Coverage is extended for FDA-approved tobacco cessation products (such as nicotine gum or patches) intended to assist an individual to stop smoking or using tobacco products**.** Present a written prescription from a physician for tobacco cessation products to the retail pharmacist. This benefit is not available through the plan's mail order program. See also the Behavioral Health row for counseling support. See the Smoking/Tobacco Cessation Program row for more information.
	• New drugs that have not yet been approved by the FDA are **not** covered. New FDA-approved drugs will be covered by the Plan if the class of drugs is a covered benefit of the Plan.
	• **Influenza vaccine (flu shot) and shingles vaccine** administered at a retail pharmacy is payable at no charge. In accordance with Health Reform, certain **over-the-counter (OTC) and prescription drugs** are payable at no charge when prescribed by a Physician or Health Care Practitioner. For details, see the OTC section in Chapter 4 "Medical Plan Options".
	• No charge for generic maintenance medication obtained at Mail Order. Also, certain Health Reform mandated drugs are payable at no charge. Contact the Prescription Drug Program for the list of maintenance medications and Health Reform mandated drugs available at no charge. Certain generic and brand name **preventive medications are payable at 100%,** no deductible when obtained at Retail or Mail Order. Contact the Prescription Drug Program for the list of preventive medications available at no charge.
	• When you take certain Specialty Drugs, such as to treat hepatitis, arthritis or multiple sclerosis, the drug manufacturer may offer a **manufacturer sponsored coupon** that together with the cost-sharing under the Medical plan may help lower the cost of the drug to you. The Plan participates in the **High Impact Advocacy Program**, administered by the Prescription Drug Program, to help manage the cost of selected specialty medications to reduce or eliminate your out-of-pocket expenses. Contact the Prescription Drug Program (listed on the Quick Reference Chart) for more information.
	• For convenience, the Plan permits you to obtain a 90-day supply of drugs at an in-network retail pharmacy location and you will pay three (3) times the normal monthly retail cost-sharing amount. The Plan permits coverage of female contraceptives prescribed by a pharmacist who is acting within the scope of his/her state license.
		Annual Prescription Drug Deductible:
		(for drugs purchased through retail or mail order)
		$75 per individual; $150 per family.
		Drugs do not accumulate to the Out of-Pocket Maximum for Coinsurance but DO accumulate to the Out-of-Pocket Limit under this Comprehensive Health Plan.
		After the deductible is met the Prescription Drug benefits are as follows:
		Network Retail Pharmacy (34-day supply):
		Generic: you pay 10% of the drug cost with a minimum of $10.00 (or the cost of the drug if less than $10.00) and maximum of $25. For Generic Contraceptives, the plan pays 100%, there's no copay/coinsurance or deductible.
		Preferred Brand: you pay 20% of the drug cost with a minimum of a $20.00 (or the cost of the drug if less than $20.00) and a maximum of $50. You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available.
		Non-Preferred Brand: you pay 50% of the drug cost with a minimum of a $50.00 (or the cost of the drug if less than $50.00) and no maximum. You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available and the difference in cost if you choose a non-preferred brand when preferred brand drug is available.
		No coverage for prescriptions filled at Wal-Mart, or at Sam's Club Retail or Mail Order locations.
		Specialty Drug Program:
		All specialty drug claims require prior approval and are limited to a 30-day supply. The copays that apply to specialty drugs depend on whether the drug is a retail claim or a mail order claim. The retail pharmacy, Mail Order pharmacy and specialty drug benefits DO NOT accumulate to a **separate prescription drug Out-of-Pocket Maximum.**
		Mail Order Service (90-day supply):
		Generic: you pay a $10 copay. For Generic Contraceptives and generic drugs used for maintenance purposes, the plan pays 100%, there's no copay/coinsurance or deductible. Contact the Prescription Drug Program for the list of permitted maintenance drugs.
		Preferred Brand: you pay a $50 copay. You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available.
		Non-Preferred Brand: you pay a $100 copay. You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available.
		Use of Out-of-Network Retail Pharmacy:
		If you fill a prescription at an out-of-network retail pharmacy, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the address of the Prescription Drug Program using the Direct Member Reimbursement (DMR) process as listed on the Quick Reference Chart. For eligible prescriptions, you pay 40% of the cost of the drug.	

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
DURABLE MEDICAL EQUIPMENT (DME) • Coverage is provided for: – **rental** (but only up to the allowed purchase price of the Durable Medical Equipment); – **purchase of standard models** at the option of the Plan; – **repair, adjustment, servicing or Medically Necessary replacement** of the DME due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired. Replacement of DME is payable once every five years only if the equipment cannot be adequately repaired at a lesser expense. • Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.	• **Continuous Positive Airway Pressure (CPAP) devices require precertification**. See the Utilization Management chapter of this document. • See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter. To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. • Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner. • For assistance in determining if proposed equipment will be payable as Durable Medical Equipment (DME) under this Plan, please contact the Claims Administrator at their contact information listed on the Quick Reference Chart in the front of this document. • While breastfeeding, coverage is provided for one standard manual or standard electric breast pump, plus necessary supplies to operate the breast pump. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from in-network providers only. No coverage out-of-network.	**Breast pump and supplies:** 100%, no deductible **All other DME:** 90% after deductible met	**Breast pump and supplies:** Not covered. **All other DME:** 50% after deductible met
EMERGENCY ROOM (ER) & URGENT CARE FACILITY SERVICES • Hospital emergency room (ER) for a medical Emergency including emergency services as that term is defined in this document. • Use of an Urgent Care facility. • Ancillary charges (such as lab or x-ray) performed **during** the ER or Urgent care visit. • (See also the Ambulance section of this schedule.)	• If an Emergency room service is subject to a copayment per visit, the copay will be waived if subsequent immediate Hospitalization is required. • Out-of-network emergency room services are payable at the in-network level of benefits only if the treatment is for an emergency, as defined by the Plan in the Definitions chapter of this document under the heading of "Emergency Care." • If a participant is treated at an In-network ER and a treating physician is an out-of-network provider, claims are paid at the in-network level of benefits up to the Allowed Charges as that term is defined in this Plan. • There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. Also, the Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with health reform Affordable Care Act regulations. See the definition of Allowed Charge or contact the medical plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers.	**Emergency Room and physician fees associated with care in the ER:** You pay a $250 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses. **Urgent Care Facility:** You pay a $50 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses.	**Emergency Room and physician fees associated with care in the ER:** You pay a $250 copay per visit, not subject to deductible, then the Plan pays 100% of eligible expenses. **Urgent Care Facility:** 50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network

ENTERAL THERAPY SERVICES
• Enteral nutritional therapy provides nourishment directly to the digestive tract of a person who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutritional formula is payable when medically necessary and all the following criteria are met:
  • When the formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and ALL of the following criteria are met:
  • Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements, and
  • The individual has one of the following conditions that is expected to be permanent or of indefinite duration:
  • an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel;
  • disease of the small bowel that impairs absorption of an oral diet;
  • a central nervous; or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.
	• Enteral therapy services are covered only when ordered by a Physician.
	• Coverage for a home enteral infusion pump (and associated necessary supplies) is considered payable when the use of the pump is medically necessary because the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion of the enteral formula.
	• Enteral nutritional formula that is not payable by the plan includes:
	  • standardized or specialized infant formula or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems.
	  • food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like.
	  • weight-loss foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and mineral.
		90%
		after deductible
		met
			50%
			after deductible
			met

FAMILY PLANNING AND CONTRACEPTIVE SERVICES • Sterilization services (e.g., vasectomy, tubal ligation, Essure). • FDA-approved contraceptives including oral birth control pills/patches, injectables (e.g., Depo-Provera), Intrauterine devices (IUD), diaphragms, implantable birth control devices.	• See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Sexual Dysfunction Services in the Exclusions chapter. • No coverage for the diagnosis or treatment of fertility and infertility. • No coverage for the diagnosis or surgical treatment of sexual dysfunction. Coverage is provided for erectile dysfunction medications under the Outpatient Prescription Drug Benefit (e.g., Viagra, Cialis, Levitra, Muse, Caverject) to a maximum of 6 doses per person per month. • No coverage for reversal of sterilization procedures.	90% after deductible met FDA approved Contraceptive methods and counseling, and Sterilization: 100%, no deductible.	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
GENETIC TESTING AND COUNSELING The genetic testing payable under this Plan is for: a. state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers); b. genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see the Preventive Services row in this Schedule). c. fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee; d. tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; e. the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants who have all the following: • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and • the covered individual displays clinical features/symptoms, or is at direct risk of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and • the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being delivered to the covered individual in conjunction with a genetic test that is payable by this Plan.	• **Genetic testing noted in "c", "d" and "e" to the left, must be precertified.** See the Utilization Management chapter of this document. • Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided and provided with regard to a genetic test that is payable by this Plan. • Certain genetic testing is payable at no cost to you. See the Preventive Services row in this Schedule. • See also the definitions of Genetic Counseling and Genetic Testing in the Definitions chapter. • No coverage for pre-parental genetic testing or any other genetic testing and counseling not related to the benefits outlined to the left. See also the Exclusions chapter for exclusions relating to Genetic Testing and Counseling.	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
HEARING BENEFITS	• See the Corrective Appliance row of this schedule.		
HOME HEALTH CARE AND HOME INFUSION SERVICES • Part-time, intermittent **Skilled Nursing Care** services and Medically Necessary supplies to provide Home Health Care or home infusion services, subject to an Annual Maximum Plan Benefit shown in the Explanations and Limitations column.	• **Home health and home infusion therapy services require precertification.** See the Utilization Management chapter of this document. • See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions chapter of this document. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner. • The Annual Maximum Benefit for Skilled Nursing Care services and supplies to provide Home Health Care, Home Infusion Services and home health aide services is **100 visits** per person per calendar year. • Home Hospice coverage is described below under Hospice benefits. Home Physical Therapy services coverage is described below under Rehabilitation Services benefits. Prescription Drugs (Medicines) coverage is described above under Drugs (Medicines) benefits.	90% after deductible met	50% after deductible met
HOSPICE • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the definition of hospice in the Definitions chapter of this document.	• **Inpatient hospice admission require precertification.** See the Utilization Management chapter of this document. • Bereavement counseling beyond that included as part of the Hospice program is payable under the Behavioral Health benefits of this Plan. • **Respite Care:** The Plan covers up to 8 days of Respite care during a Hospice benefit. Respite care may include expenses for medical services and supplies when confined in a facility maintained by a hospice agency when such confinement is for respite care to relieve the person residing with and caring for the terminally ill patient in his/her home.	90% after deductible met	Home Hospice: 50% after deductible met Inpatient Hospice: Not covered.
LABORATORY SERVICES (Outpatient) • Technical and professional fees.	• **Sleep studies (called polysomnography) and certain genetic testing (see the Genetic testing row) require precertification.** See the Utilization Management chapter of this document. • Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Certain lab testing is payable at no cost to you. See the Preventive Services row in this Schedule.	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
MATERNITY SERVICES • Hospital and Birth (Birthing) Center charges and Physician and Midwife fees for Medically Necessary maternity services. • One routine ultrasound per pregnancy is payable. • Termination of pregnancy is covered only when the attending Physician certifies that the female Employee or Spouse's health would be endangered if the fetus were carried to term or where complications arise from an abortion. • See Genetic Testing for additional information. • The Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a qualified provider, while breastfeeding, at 100%, no deductible for all females, when provided by an in-network provider. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.	• **Prenatal and postnatal office visits, breast pump and supplies, lactation counseling and Health Reform –mandated preventive services are payable for all females with no cost-sharing when performed by an in-network provider**. • Pregnancy-related care is covered for a female Employee or Spouse only. For an employee or spouse, normal plan cost-sharing applies to all other maternity related services including an ultrasound and delivery fees. • Expenses related to a complication of a pregnancy of a Dependent Child are payable at normal cost-sharing. **No coverage is provided for delivery-related expenses of a pregnant dependent child and their newborn**. • Certain prenatal care and preventive expenses for pregnant women (as listed on the government website at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to screening for gestational diabetes, breastfeeding supplies, rental of breast feeding equipment and, comprehensive lactation support and counseling by a trained provider while breastfeeding are covered under the Wellness/Preventive Services category without cost sharing from in-network providers for a female Employee, Spouse and Dependent Child. See the exclusions related to Maternity Services in the Exclusions chapter. • See also, the Special Rule for Coverage of Newborn Dependent Children in the Eligibility chapter. • **Hospital Length of Stay for Childbirth:** The Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).	**Prenatal and postnatal office visits and Health Reform mandated preventive care:** 100%, no deductible. Breastfeeding equipment and supplies: See the DME row. **Breastfeeding Lactation counseling:** 100%, no deductible **All other maternity services for an Employee or Spouse including an ultrasound and professional delivery fees:** 90% after deductible met **For a pregnant dependent child** you pay 100% for certain prenatal tests like ultrasounds and delivery expenses.	**For an Employee or Spouse:** 50% after deductible met **For a pregnant dependent child** the Plan does not pay, and instead you pay expenses beyond office visits and Health Reform mandated preventive services, meaning you pay for services such as ultrasounds and delivery expenses.

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
NONDURABLE SUPPLIES Coverage is provided for: • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. • Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under the Prescription Drug Program.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
ORAL, CRANIOFACIAL, AND TMJ SERVICES • Accidental Injury to Teeth. • Temporomandibular Joint (TMJ) dysfunction or syndrome. • Oral and/or Craniofacial Surgery. • Oral Surgery only for services noted to the right.	• See the Dental Services exclusions in the Exclusions chapter. • **Alveolar ridge reconstruction** is payable including the use of hydroxylapatite particles and inserts for augmentation of mandibular and maxillary alveolar ridges provided the Claims Administrator receives documentation of treatment for ulceration, appropriate dental x-rays and documentation that the patient has been wearing dentures for at least 10 years. • **Treatment of Accidental Injuries to the Teeth:** The Plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met: – The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and – The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and – The dental treatment will return the person's teeth to their pre-injury level of health and function. See the definition of Injury to Teeth in the Definitions chapter of this document. • **Treatment of Temporomandibular Joint (TMJ) dysfunction or syndrome is payable only if preauthorized** through the Utilization Management Company. See the Utilization Management chapter of this document. **Medically necessary surgery for TMJ syndrome/dysfunction is payable to a maximum of $5,000 per person per lifetime.** • **Oral or craniofacial surgery** is limited to cutting procedures to remove tumors/cysts. No coverage for dental services such as removal of wisdom teeth, extraction of boney impacted teeth, root canal, gingivectomy, or dental abscess treatment. • Coverage is provided by the Plan for up to $10,000 per person per calendar year to a maximum of $25,000 per person per lifetime for eligible dental services resulting from Medically Necessary **orthognathic surgery**. Coverage is payable for orthognathic surgery for the treatment of prognathism, retrognathism and other reasons if determined by the Plan Administrator or its designee to be Medically Necessary and not cosmetic.	90% after deductible met	50% after deductible met
OUTPATIENT (Ambulatory) SURGERY • Ambulatory (Outpatient) Surgical Facility or Center. • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• **Admission to an outpatient surgical facility requires precertification.** See the Utilization Management chapter for details. • Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services if the utilization management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this medical plan.	90% after deductible met	50% after deductible met

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
PREADMISSION TESTING (Outpatient) • Laboratory tests, x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.	• Covered only when ordered by a Physician or Health Care Practitioner.	90% after deductible met	50% after deductible met
RADIOLOGY (X-Ray), NUCLEAR MEDICINE AND RADIATION THERAPY SERVICES (Outpatient) • Technical and professional fees associated with diagnostic and curative services, including radiation therapy. • One routine ultrasound per pregnancy.	• **The following tests and diagnostic procedures require precertification: Magnetic Resonance Imaging (MRI) scan, CT scan, Endoscopy, and Colonoscopy.** See the Utilization Management chapter of this document. • Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered under the Preventive Services Programs described under Wellness in this Schedule.	90% after deductible met	50% after deductible met
RECONSTRUCTIVE SERVICES AND BREAST RECONSTRUCTION AFTER MASTECTOMY • The Plan complies with the **Women's Health and Cancer Rights Act** 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.	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter. Most Cosmetic services are excluded from coverage. • Reconstructive Surgery is payable if such procedures or treatment are necessary for the repair or alleviation of damage resulting from a disability caused by accidental bodily injuries sustained by a Participant, trauma, infection or disease of the involved part or the surgery is necessary because of congenital disease or anomaly of a Dependent Child which has sustained a functional defect.	90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
REHABILITATION SERVICES (Cardiac and Pulmonary) • **Cardiac Rehabilitation** is available to individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.). • **Pulmonary Rehabilitation** is available to individuals who are able to actively participate in a Pulmonary Rehabilitation program that is likely to improve their pulmonary condition, as determined by the Plan Administrator or its designee.	• **Cardiac rehabilitation services require precertification**. See the Utilization Management chapter of this document. • Cardiac and Pulmonary Rehabilitation programs must be ordered by a Physician. • See also the Definition of Cardiac Rehabilitation in the Definitions chapter of this document.	90% after deductible met	50% after deductible met
REHABILITATION SERVICES (Occupational, Physical, and Speech Therapy) • Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.**	• **Physical and occupational therapy after three initial visits requires precertification. Inpatient rehabilitation admission requires precertification**. See the Utilization Management chapter for details. • Maintenance Rehabilitation, habilitation, and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation Therapies in the Exclusions chapter. • Rehabilitation services are covered only when ordered by a Physician. • **Speech therapy which is to last beyond two months must be precertified through the Utilization Management firm.** See the Utilization Management chapter of this document. • **Speech therapy** is covered if provided by a licensed or duly qualified speech therapist to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Speech therapy for functional purposes, (including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin) or childhood developmental speech delays and disorders are excluded from coverage.	90% after deductible met	Inpatient rehabilitation admission: Not covered. All other rehabilitation services: 50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
ROUTINE COSTS RELATED TO CLINICAL TRIALS • Routine patient costs for all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. • The Clinical Trial must be approved as a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition as more fully described by law. A life threatening condition is any disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.	• **Clinical Trial Participation is subject to precertification for the purpose of (i) determining whether you are a "qualified individual", (ii) to verify that the trial is an "approved clinical trial" within the meaning of the law and (iii) to determine whether there exists an in-network clinical trial that will accept you as a participant.** • A "qualified individual" must be eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition and either: (i) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or (ii) the individual provides medical or scientific information establishing that the individual's participation in such trial would be appropriate based upon the above conditions. • **The level of Plan coverage of routine costs will be based on whether the items or services are provided through in-network or out-of network providers. If one or more in-network providers is participating in a clinical trial the Plan requires that a qualified individual participate in the in-network provider's clinical trial if the participating provider will accept the individual as a participant in the trial.** • "Routine patient costs" do not include (i) the investigational item, device or service itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	**Routine Costs Related to your Clinical Trial Participation** Coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan.	**Routine Costs Related to your Clinical Trial Participation** Coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan.
SKILLED NURSING FACILITY (SNF) OR SUBACUTE FACILITY • Skilled Nursing Facility (SNF). • Subacute Care Facility.	• Services must be ordered by a Physician. To determine if a facility is a skilled nursing or subacute facility see the Definitions chapter of this document. • **Admission to a Skilled Nursing Facility confinement or Subacute care facility confinement requires precertification.** See the Utilization Management chapter for details. • **Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to 120 days per calendar year.**	90% after deductible met	Not covered.

SMOKING/TOBACCO CESSATION PROGRAMS
• This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco). This benefit includes:
  • Acupuncture as a treatment for tobacco cessation.
  • Low level laser therapy as a treatment for tobacco cessation.
	• Coverage is extended for programs intended to assist an individual to stop smoking or using tobacco products. This coverage includes these tobacco cessation treatment options: low level laser therapy or acupuncture. No coverage for hypnosis or massage therapy.
	• Claims for over-the-counter tobacco cessation products are able to be reimbursed by the Plan at 100% with a prescription. See the Drug row of this Schedule of Medical Benefits for information on coverage of drugs to help with tobacco cessation.
	• See the Behavioral Health Services row for information on counseling that can be used to treat a nicotine addiction.
		90% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
TRANSPLANTS (Organ and Tissue) • Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue and **only for the following:** heart, kidney, cornea, bone marrow, lung, liver, heart/lung, pancreas and kidney/pancreas, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Coverage includes: – charges for the live donor for removal of a donated organ/tissue for a preauthorized transplant to a Participant or, – for a Participant who is a live donor, for removal of a donated organ when the organ is one which would have been covered if the recipient were a Participant and when the recipient's insurance specifically excludes coverage for charges incurred by a donor; or – Cadaver donor expenses. • No coverage for expenses incurred by a person who donates an organ or tissue, unless the person who receives the donated organ/tissue is the person covered by the Plan.	• See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter. • **Transplant services (including pre-transplant workup tests) are subject to precertification.** See the Utilization Management chapter for details. • Donor expenses are payable to a maximum of $20,000 per person per transplant. • **Out-of-Network Transplant Maximums:** The Plan pays up to the maximums noted below: – Heart: $110,000 including a max of $20,000 for physician services. – Lung: $155,000 including a max of $20,000 for physician services. – Bone Marrow: $130,000 including a max of $20,000 for physician services. – Liver: $130,000 including a max of $20,000 for physician services – Heart/Lung: $150,000 including a max of $20,000 for physician services. – Pancreas: $70,000 including a max of $20,000 for physician services. – Kidney: $55,000 including a max of $20,000 for physician services. – Kidney/Pancreas: $95,000 including a max of $20,000 for physician services. • **Transplant Related Travel Benefit:** The Plan benefit for transplant related travel expenses, including transportation, lodging for the patient and one family member or companion is $10,000 per transplant. Reimbursement is available for round trip "coach" airfare, and up to a maximum of $200 per day for lodging received during the pre-operative work-up, transplant operation and post-transplant treatment phases. Receipts are required when submitting lodging, and travel expenses for payment consideration. The IRS allows $50 per day to be received on a tax free basis. Any amounts in excess of $50.00 per day will be treated as taxable income to the employee and the Plan Administrator will be responsible for preparing a 1099 to report that income. – The following expenses will not be reimbursed by the Plan: meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and expenses for persons other than the patient and his/her designated family member/travel companion.	90% after deductible met	50% after deductible met up to the maximums noted to the left under Explanations
VISION SERVICES		See the chapter on the Vision Plan.	See the chapter on the Vision Plan.

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
WELLNESS - PREVENTIVE SERVICES PROGRAM: WELL CHILD EXAMINATIONS AND IMMUNIZATIONS • Outpatient newborn and well child visits and routine childhood immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"), including flu shots. • Wellness and preventive services are payable as listed on the websites shown in the column to the right. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • For children age 6 years and older with obesity, the Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • Performed in primary practices, **topical fluoride** varnish to the primary teeth of children through age 5 years. • In this section and the following section on Preventive Services the term "cost-sharing" is used to refer to costs you would pay under the Plan, such as deductibles, coinsurance and copayments. • If the Plan does not have in its network a provider who can provide a particular required preventive service, then the Plan will cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.	The preventive services payable by this plan (without cost-sharing on your part) are designed to comply with Health Reform regulations. With respect to infants, children and adolescents, evidence-informed preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) are covered as well as immunizations for routine use in children, and adolescents that are recommended by the Advisory Committee on Immunization Practices (ACIP). For complete and up-to-date information see https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. In addition to the wellness/preventive services listed on the websites here, the Plan will pay for well child office visits. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services. • When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance and deductible) will apply to the diagnostic or therapeutic services provided. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. Services not covered under the Preventive Services wellness benefit may be covered under another portion of the medical plan. • If your in-network health care provider prescribes a vaccine consistent with the ACIP recommendations, the Plan will provide coverage without cost-sharing. New ACIP recommendations will be covered without cost-sharing starting with the Plan year that begins on or after the date that is one year after the date the recommendation is issued. • See the Special Rule for Coverage of Newborn Dependent Children in the Eligibility chapter. • See the exclusion of expenses for physical examinations and testing required for school, camp, recreation, sports, etc., in the Exclusions chapter.	100% no deductible	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE COMPREHENSIVE HEALTH PLAN

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Benefit Description	Explanations and Limitations of Benefits	COMPREHENSIVE HEALTH PLAN	
		In-Network	Out-of-Network
WELLNESS - PREVENTIVE SERVICES PROGRAM: ADULT HEALTH MAINTENANCE EXAMINATIONS (for Active Employees, their Spouse and Dependent Children as appropriate) including: • Complete history and physical examination; x-ray charges for chest x-ray; routine screening mammogram; annual gynecology exam for purpose of obtaining a pap smear; laboratory charges for complete blood count, urinalysis, pap smear, and prostate blood test (PSA); screening colonoscopy; CDC-recommended immunizations including flu shots. See also Well Child Examinations and Immunizations . • Preventive Services consist of 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 ("USPSTF") with respect to the individual involved. Preventive Services also includes immunizations for routine use in adults that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"). • With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") to the extent not already included in certain recommendations of the USPSTF. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • If any recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a service, the Plan will use reasonable medical management techniques to determine any coverage limitations. • The Plan recognizes that certain USPSTF recommendations apply to certain individuals identified as "high-risk" due to factors such as family or personal history of disease. Therefore, if the attending provider determines that a patient belongs to a high-risk population and a USPSTF recommendation applies to that high-risk population, any preventive item or service recommended by the USPSTF in connection with such high-risk individual will be covered without cost-sharing subject to reasonable medical management. • If the Plan does not have in its network a provider who can provide a particular required preventive service, then the Plan will cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.	The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). These websites list the types of payable preventive services (such as immunizations, mammogram, pap smear, and screening colonoscopy): https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. In addition to the Preventive Services listed on the website above, the Plan will pay for these Preventive Services: an annual (although in some circumstances several visits may be necessary depending on health factors) wellness/physical exam for adults, annual prostatic specific antigen (PSA) lab test for men, screening mammogram for women at any age, chest x-ray, EKG. complete blood count and urinalysis. A screening colonoscopy (including anesthesia) is payable for participants age 50 years and older once every five years. • For people with certain health conditions, over-the-counter ("OTC") medications may be recommended by their health care provider, When OTC medications are recommended by the USPSTF and prescribed by your health care provider the Plan will cover such OTC medications without cost-sharing. Contraceptive methods must be FDA-approved and prescribed for a woman by her health care provider. The HRSA guidelines do not include contraception for men. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. Under certain circumstances as stated in regulatory guidance, some procedures, such as polyp removal during a screening colonoscopy are considered an "integral part" of the preventive service. In these circumstances the Plan will not impose cost- sharing on you. However, the Plan will impose cost- sharing for a treatment that is not a recommended preventive service even if the treatment results from a recommended preventive service. • For women's preventive services, genetic counseling and an evaluation for routine breast cancer susceptibility gene (BRCA) may include without cost-sharing the BRCA test itself, if appropriate, as determined by your health care provider. • **Women's Preventive Services:** HRSA Guidelines recommend at least one annual well-woman preventive care visit for adult women to obtain the recommended preventive services without cost-sharing that are age and developmentally appropriate including preconception and prenatal care. Additional preventive care visits (without cost-sharing but subject to reasonable medical management) may be necessary depending on a woman's health status, health needs and other risk factors as determined by the clinician .HRSA guidelines recommend annual HIV counseling and screening (which includes testing) for sexually active adult women and high-risk HPV DNA testing every three years for women as age and risk appropriate. HRSA Guidelines ensure women's access to the full range of FDA-approved contraceptive methods. However, the Plan will impose cost-sharing for brand name contraceptive drugs or other pharmacy products when a generic drug is available subject to medical appropriateness as determined by the individual's health care provider. Services related to follow-up and management of contraceptive side effects, counseling for continued adherence and device removal are covered without cost-sharing and subject to reasonable medical management. Comprehensive prenatal and postnatal lactation support, breastfeeding counseling and lactation equipment rental or, if appropriate, purchase, are covered for the duration of breastfeeding without cost-sharing and subject to reasonable medical management. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency and method to the extent not specified in a recommendation or guideline. Services not covered under the wellness benefit may be covered under another portion of the medical plan. • If your in-network health care provider prescribes a vaccine consistent with the Advisory Committee on Immunization Practices (ACIP) recommendations, the Plan will provide coverage without cost-sharing. New ACIP recommendations will be covered without cost-sharing starting with the Plan year that begins on or after the date that is one year after the date the recommendation is issued.	100%, no deductible	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
DEDUCTIBLE • Is the amount you must pay each calendar year before the Plan pays benefits. • Deductibles under this Plan are accumulated on a Calendar Year basis.	• Note that services from In-Network and Out-of-Network providers are combined to meet your annual deductible amounts. • For families enrolled in the HDHP option, IRS regulations require that the family (**including any individual in the family**) must meet the IRS-mandated minimum family deductible (e.g. $$2,700/family in 2018) before any reimbursement is made for eligible medical expenses (other than for preventive care). • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are received by the Plan. • The amount applied to the deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan.	$2,500/person $2,700 per person in the family $5,000/family	$5,000/person $10,000/family
OUT-OF-POCKET LIMIT ON IN-NETWORK COST-SHARING • This Out-of-Pocket Limit is the **maximum amount of deductibles, copayment and coinsurance** you are responsible for paying each calendar year related to in-network essential health benefits, **before** the Plan pays the remainder of your eligible claims that year. • Some out-of-pocket expenses do not apply to this Out-of-Pocket Limit, as described to the right. • (This CDHP Plan does NOT also have an Out-of-Pocket Maximum on Coinsurance.) • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person in a family" annual out-of-pocket limit.	• The Out-of-Pocket Limit is accumulated on a calendar year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Plan. • Effective January 1, 2015, covered outpatient prescription drugs accumulate to the in-network cost-sharing Out-of-Pocket Limit. • **The Out-of-Pocket Limit does not include or accumulate:** a. **Premiums and contributions** for coverage, b. Expenses for medical services or supplies that are **not covered** by the Plan, c. **Charges in excess of the Allowed Charge** determined by the Plan which includes balance billed amounts for non-network providers, d. **Penalties for non-compliance** with Utilization Management programs, e. Expenses for the **use of non-network providers**, except emergency services performed in an out-of-network Emergency Room will accumulate to the in-network Out-of-Pocket limit, f. Charges **in excess of the Medical Plan's Maximum Benefits**, g. **Dental Plan and Vision Plan** expenses, h. Certain services or items with respect to which the Plan exercises its discretion to define as **not "Essential Health Benefits"** including but not limited to: 1) An individual's **out-of-pocket costs for a brand name prescription drug in circumstances in which** a generic was available and medically appropriate. The difference between the cost of the brand name drug and the cost of the generic drug will not be counted toward your Out of-Pocket Limit. In determining whether a generic is medically appropriate, the Plan will use a reasonable exception process, for example, the Plan may defer to the recommendation of an individual's personal physician, or it may offer an exceptions process meeting the requirements of 45 CFR 156.122(c). 2) Any service or item for which the **Plan imposes an annual maximum**, for example, acupuncture and chiropractic.	$6,450/person $6,450 per person in the family $12,900/family	No limit.

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

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Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
HOSPITAL SERVICES (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms.	• **Inpatient hospitalization is subject to precertification**. All Hospitalization is subject to concurrent review. See the Utilization Management chapter for details. There is a $200 penalty for failure to precertify. • Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services if the Utilization Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or assistant dental provider fees under this medical plan. • See the Eligibility chapter for how to properly enroll Newborns so coverage can be considered.	80% after deductible met	50% after deductible met

PHYSICIAN AND OTHER HEALTH CARE PRACTITIONER SERVICES
• Physician and Health Care Practitioner professional fees for services provided in a Hospital, Urgent Care Center, Health Care Facility, an office or at home, except as otherwise indicated in the Schedule of Medical Benefits.
• For payment of emergency services in an Emergency Room, see the Emergency Room row of this Schedule.
• Payable Physician and Health Care Practitioners include:
  • Surgeon;
  • Assistant surgeon (if Medically Necessary);
  • Anesthesia provided by Physicians, and/or Certified Registered Nurse Anesthetists (CRNA);
  • Pathologist; Radiologist;
  • Physician Assistant;
  • Nurse Practitioner; Nurse Midwife;
  • Podiatrist;
  • Breastfeeding/Lactation Educator (see the Maternity row for information).
	• **Some Physician and Health Care Practitioner services are subject to precertification. Certain tests require precertification, such as: Endoscopy and Colonoscopy.** See the Utilization Management chapter of this document for additional details.
	• **Primary Care Physician (PCP)** means a Physician or other Health Care Practitioner who practices general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology (OB/GYN). All other Physicians are considered specialists under this Plan.
	• The Plan Administrator or its designee will determine if multiple surgical or medical procedures will be covered as separate procedures or as a single procedure based on the definition of "Surgery" in the Definitions chapter.
	• Assistant Surgeons:
	  – Physicians who act as an Assistant Surgeon will be reimbursed for Medically Necessary services to a maximum of **20%** of the eligible expenses payable to the primary surgeon.
	  – All other health care practitioners who act as an Assistant Surgeon (e.g., physician assistant, nurse practitioner) will be reimbursed for Medically Necessary services to a maximum of **15%** of the eligible expenses payable to the primary surgeon. Certified Surgical Assistants (as defined by the Plan) are not payable.
	• See also "Prophylactic, Prophylactic Surgery" as defined in the Definitions chapter and the Prophylactic Surgery or Treatment Exclusions in the Exclusions chapter.
	• Coverage is provided for intravenous (IV) iron therapy when it is determined by the Plan to be Medically Necessary. **IV iron therapy requires precertification.** See the Utilization Management chapter for details on how to precertify.
	• Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
		80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

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Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
ACUPUNCTURE	• Payable to a maximum of $500 per person per calendar year if services are ordered by a Physician. This benefit limit does not apply to acupuncture used as a treatment for tobacco cessation. • Services are covered only if the HealthCare Practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided.	80% after deductible met	50% after deductible met
ALLERGY SERVICES • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician. Desensitization injections are covered only when provided by a licensed Health Care Practitioner.	Testing, Allergy Shots and Antigen: 80% after deductible met	Testing, Allergy Shots and Antigen: 50% after deductible met
AMBULANCE SERVICES • **Ground vehicle transportation** to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency, acute illness or inter-health care facility transfer. • **Air transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.	• Expenses for **ground vehicle ambulance services are covered only when those services are for an Emergency** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care." • Non-emergency medical transportation refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-emergency medical monitoring during transport. **Non-emergency medical transportation services are payable when precertified**.	80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
BEHAVIORAL HEALTH SERVICES (Mental Health and Substance Abuse Treatment) • **EAP Services:** The Plan provides an EAP Program that offers up to **8 free counseling visits** to the EAP. Contact the EAP Program whose name is listed on the Quick Reference Chart. • **Behavioral Health Services:** – **Inpatient**: means hospitalization at a Behavioral Health Treatment Facility or hospital that provides an area dedicated to behavioral health treatment. Inpatient also includes an admission to an in-network residential treatment program (as the term is defined in the Definitions chapter). – **Outpatient**: means office visits. Other outpatient services include partial hospitalization and intensive outpatient treatment program. – **Psychological (Psychiatric) Testing**. – **Chronic pain control and pain rehabilitation** payable as part of Behavioral Health Services. – **Applied Behavioral Analysis Therapy.** See the definitions chapter.	• **EAP Services:** The Plan provides an EAP Program. When you are enrolled in one of the medical plan options you and your Dependents are eligible to use the EAP services for information and/or free confidential counseling visits for a wide range of problems and illnesses including stress, depression, anxiety, work life services, etc. EAP benefits are provided through a contracted EAP Program whose name and phone number are listed on the Quick Reference Chart in the Introduction chapter of this document. • **Inpatient hospitalization and residential treatment program admission requires precertification** by calling the Behavioral Health Program whose phone number is listed on the Quick Reference Chart in the front of this document. • **Residential treatment program** is covered (from in-network providers only) for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. See the definition of Residential Treatment Program. **Precertification is required**. • See the specific exclusions related to Behavioral Health Services in the Exclusions chapter. • Benefits are payable for services of Behavioral Health Care Practitioners listed in the Definitions chapter. • Outpatient prescription drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. • You may use these Behavioral Health services for counseling assistance for tobacco addiction.	**EAP:** 100%, no deductible applies **Inpatient:** 80% after deductible met **Outpatient Office Visit:** 80% after deductible met **All other services:** 80% after deductible met	**Residential Treatment Program:** Not covered. **All other services:** 50% after deductible met
BLOOD TRANSFUSIONS • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician and if blood is not replaced at the blood bank. • Expenses related to autologous blood donation (patient's own blood) are covered.	80% after deductible met	50% after deductible met
CHEMOTHERAPY • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.		80% after deductible met	50% after deductible met
CHIROPRACTIC SERVICES • Chiropractic services include office visits, x-rays and manipulations performed by a Chiropractor.	• Chiropractic services are payable to a maximum of $50 per visit not to exceed $500 per person per calendar year.	80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
CORRECTIVE APPLIANCES (Prosthetic and Orthotic Devices, Other Than Dental) • Coverage is provided for Medically Necessary corrective appliances as follows: – rental (but only up to the allowed purchase price of the device). – purchase of standard models at the option of the Plan. – repair, adjustment or servicing of the device or replacement of the device due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. • Colostomy or ostomy (orthotic) supplies. • Hearing Aid. • Corrective shoes or supportive devices for the feet including orthotics are not payable unless they are an integral part of a lower body brace.	• **Prosthetic devices require precertification**. See the Utilization Management chapter for details. • Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner. • Replacement or repair of a prosthetic device is payable once in a five-year period provided prior authorization has been obtained from the Utilization Management company. For precertification, see the Utilization Management chapter for details. • **Hearing Aid Benefit:** The Plan pays up to $500 per person every three years toward the purchase, servicing, fitting and/or repair of Medically Necessary external hearing aid devices. However, for Dependent Children with an audiology exam revealing bilateral hearing loss of 30 decibels or greater, the Plan allows an additional payment up to $1,500 per person every three years toward the purchase, servicing, fitting and/or repair of Medically Necessary hearing aid devices. • Coverage is provided under this Medical Plan for an implantable hearing device (such as a cochlear implant,) for children, when determined to be Medically Necessary by the Claims Administrator or its designee, that meets all of the following parameters: – Children 12 months of age or older with bilateral sensorineural hearing impairment with thresholds of 90 dB or greater at 1000 Hz; and limited benefit from appropriately-fitted binaural hearing aids. – Replacement speech processors and other external parts associated with implantable hearing devices for children are payable when determined to be Medically Necessary by the Claims Administrator or its designee because the existing device cannot be repaired or replacement is required because a change in the person's condition makes the present unit non-functional and improvement is expected with a replacement unit. • See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter.	80% after deductible met	50% after deductible met
DENTAL SERVICES		Not Covered See also the Dental Plan chapter.	Not Covered See also the Dental Plan chapter.
DIALYSIS • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Covered when order by a Physician. • **It is required that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. • See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible.	80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
DIETARY SERVICES • Benefits are payable for nutritional counseling to assist individuals with their nutritional health and dietary needs. Services can be used for assistance with food choices when diagnosed with such diseases as obesity, high blood pressure, cardiac disease, diabetes, high cholesterol, allergies, kidney disease, etc. • Services are payable only when performed by a Registered Dietician or licensed or certified Nutritionist.	• Services of a Registered Dietician or licensed or certified Nutritionist are payable to a maximum of 5 visits per person per calendar year. This visit limit does not apply to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health or substance abuse condition. • As a preventive counseling benefit in compliance with Health Reform, the Plan covers the following services: For adults (1) with a body mass index of 30 kg/m^2 or higher, OR (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m^2) or obese (defined as a BMI of 30 kg/m^2 or higher) AND have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed **intensive behavioral counseling** interventions. Intensive behavioral counseling interventions means the Plan will consider as medically necessary preventive services, up to a combined limit of 26 individual or group visits per 12-month period by an in-network provider. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician. • This dietary counseling is payable as a Wellness service in accordance with Health Reform requirements.	100%, no deductible	Not Covered

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network

DRUGS (Outpatient Prescription Medicines)
• Coverage is provided only for those pharmaceuticals (drugs & medicines) approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner. Drugs required to be covered by Health Reform law are also covered.
• Coverage is also provided for FDA approved contraceptives such as birth control products/pills, and injectable contraceptives like Depo-Provera; Insulin and diabetic supplies such as lancets, insulin syringes, alcohol swabs, blood and urine testing agents and strips; Glucagon, bee sting kits.
• Contact the Prescription Drug Program (the phone number is listed on the Quick Reference Chart in the front of this document) for the following:
  • Drugs on the **Preferred Drug formulary**.
  • **Certain drugs need preapproval** by the clinical staff of the Prescription Drug Program to avoid non-payment, such as injectables, attention deficit disorder medications, erectile dysfunction medication for BPH, growth hormone, Retin A, proton pump inhibitors (PPIs) to treat stomach ulcers and gastroesophageal reflux disease, proprotein convertase subtilisin kexin 9 (PCSK9) inhibitors, and non-sedating antihistamines (NSAH). Coverage for prescription NSAHs is payable only when treatment with Claritin has failed or treatment is for pet dander allergies. Other medications included in the Clinical Programs of the Prescription Drug Provider such as Specialty Drugs may also require preapproval. **There will be no coverage for any of these medications unless preapproved**.
  • Drugs that have a **limit to the quantity payable** by the Plan such as certain medication for pain, fungus, sleeping, migraine and asthma. Erectile dysfunction drugs (e.g. Viagra, Cialis, Muse, Caverject) payable up to 6 doses per month; when preapproved, a daily dose is payable for treatment of benign prostatic hypertrophy (BPH).
  • Information on which drugs are part of the **Step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug treatment option. For example, currently these drugs or classes of drugs require step therapy: Lyrica, nasal sprays, beta blockers, sleep medication, Cox-2 anti-inflammatory drugs and drugs to treat elevated blood pressure (ARBs), osteoporosis, depression, overactive bladder, statins for elevated cholesterol, and migraines.
  • **Specialty Drugs** are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are products derived from living organisms used by individuals with unique health concerns and include items such as injectables and infusibles for multiple sclerosis, cancer or hepatitis. These **drugs need precertification** and are managed because they often require special handling, are date sensitive and are usually available only in a 30-day quantity.
	• Your best price for prescriptions are those provided through the Plan's contracted Prescription Drug Program, whose name is listed on the Quick Reference Chart in the Introduction chapter of this document. This Prescription Drug Program pays for generic drugs, unless a generic is not available. If you choose to have your prescription filled with a brand name drug when a generic drug is available, you will pay the copay and coinsurance noted to the right plus the difference in cost between the brand and generic drug. If no generic drug is available the Plan will pay for a brand name drug.
	• **Retail Drugs**: To obtain a 34-day supply of medication for the cost-sharing noted to the right, present your ID card to any in-network retail pharmacy. You can find the location of in-network retail pharmacies by contacting the Prescription Drug Program whose name is listed on the Quick Reference Chart in the front of this section of the handbook.
	• **Mail Order (Home Delivery) Service:** The mail order service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. To use the mail order service, have your physician write the prescription for a 90-day supply, with the appropriate refills. Mail your prescription, copay and the mail order form to the Mail Order Services of the Prescription Drug Program whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the customer service or website of the Prescription Drug Program. Allow up to 14 days to receive your order.
	• Copayments for Mail Order drugs are not applied to the Plan's Deductibles.
	• The retail pharmacy, mail order pharmacy and specialty drug benefits do accumulate to the medical plan Out-of-Pocket Limit.
	• Growth hormone medication requires precertification and is payable only when Medically Necessary for individuals with documented growth hormone deficiency or, cachexia (a severe muscle, fat and weight loss syndrome) not remedied by other means, as determined by the professionals of the Prescription Drug Program.
	• Certain classes of drugs are not payable under this Plan such as drugs for treatment of obesity, cosmetic drugs, and fertility/infertility. See the exclusions related to Drugs (Medicines) in the Exclusions chapter for details on non-covered drugs.
	• **Tobacco/smoking cessation benefit**: Coverage is extended for FDA-approved tobacco cessation products (such as nicotine gum or patches) intended to assist an individual to stop smoking or using tobacco products. Present a written prescription from a physician for tobacco cessation products to the retail pharmacist. This benefit is not available through the plan's mail order program. See also the Behavioral Health row for counseling support. See the Smoking/Tobacco Cessation Program row for more information.
	• New drugs that have not yet been approved by the FDA are **not** covered. New FDA-approved drugs will be covered by the Plan if the class of drugs is a covered benefit of the Plan.
	• **Influenza vaccine (flu shot) and shingles vaccine** administered at a retail pharmacy is payable at no charge. In accordance with Health Reform, certain **over-the-counter (OTC) and prescription drugs** are payable at no charge when prescribed by a Physician or Health Care Practitioner. For details, see the OTC section in Chapter 4 "Medical Plan Options".
	• No charge for generic maintenance medication obtained at Mail Order. Also, certain Health Reform mandated drugs are payable at no charge. Contact the Prescription Drug Program for the list of maintenance medications and Health Reform mandated drugs available at no charge. Certain generic and brand name **preventive medications are payable at 100%,** no deductible when obtained at Retail or Mail Order. Contact the Prescription Drug Program for the list of preventive medications available at no charge.
	• When you take certain Specialty Drugs, such as to treat hepatitis, arthritis or multiple sclerosis, the drug manufacturer may offer a **manufacturer sponsored coupon** that together with the cost-sharing under the Medical plan may help lower the cost of the drug to you. The Plan participates in the **High Impact Advocacy Program**, administered by the Prescription Drug Program, to help manage the cost of selected specialty medications to reduce or eliminate your out-of-pocket expenses. Contact the Prescription Drug Program (listed on the Quick Reference Chart) for more information.
	• For convenience, the Plan permits you to obtain a 90-day supply of drugs at an in-network retail pharmacy location and you will pay three (3) times the normal monthly retail cost-sharing amount. The Plan permits coverage of female contraceptives prescribed by a pharmacist who is acting within the scope of his/her state license.
		After the CDHP medical plan deductible is met,
		the Prescription Drug benefits are as follows.
		
		Outpatient prescription drug expenses **do** accumulate to the Out-of-Pocket Limit under this CDHP.
		
		Network Retail Pharmacy (34-day supply):
		Generic: you pay 10% of the drug cost with a minimum of $5.00 (or the cost of the drug if less than $5.00). For Generic Contraceptives, the plan pays 100%, there's no copay/coinsurance or deductible.
		Preferred Brand: you pay 20% of the drug cost with a minimum of a $10.00 (or the cost of the drug if less than $10.00). You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available.
		Non-Preferred Brand: you pay 20% of the drug cost with a minimum of a $10.00 (or the cost of the drug if less than $10.00). You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available and the difference in cost if you choose a non-preferred brand when preferred brand drug is available.
		No coverage for prescriptions filled at Wal-Mart or Sam's Club Retail or Mail Order locations.
		Specialty Drug Program:
		All specialty drug claims require prior approval and are limited to a 30-day supply. The copays that apply to specialty drugs depend on whether the drug is a retail claim or a mail order claim.
		Mail Order Service (90-day supply):
		Generic: you pay a $10 copay. For Generic Contraceptives and generic drugs used for maintenance purposes, the plan pays 100%, there's no copay/coinsurance or deductible. Contact the Prescription Drug Program for the list of permitted maintenance drugs.
		Preferred Brand: you pay a $20 copay. You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available.
		Non-Preferred Brand: you pay a $40 copay. You also pay the difference in cost between the brand and generic drug if you choose a brand name drug when a generic drug is available.
		Use of Out-of-Network Retail Pharmacy:
		Not covered.	

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
DURABLE MEDICAL EQUIPMENT (DME) • Coverage is provided for: – **rental** (but only up to the allowed purchase price of the Durable Medical Equipment); – **purchase of standard models** at the option of the Plan; – **repair, adjustment, servicing or Medically Necessary replacement** of the DME due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired. Replacement of DME is payable once every five years only if the equipment cannot be adequately repaired at a lesser expense. • Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.	• **Continuous Positive Airway Pressure (CPAP) devices require precertification**. See the Utilization Management chapter of this document. • See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter. To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. • Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner. • For assistance in determining if proposed equipment will be payable as Durable Medical Equipment (DME) under this Plan, please contact the Claims Administrator at their contact information listed on the Quick Reference Chart in the front of this document. • While breastfeeding, coverage is provided for one standard manual or standard electric breast pump, plus necessary supplies to operate the breast pump. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from in-network providers only. No coverage out-of-network.	**Breast pump and supplies:** 100%, no deductible **All other DME:** 80% after deductible met	**Breast pump and supplies:** Not covered. **All other DME:** 50% after deductible met
EMERGENCY ROOM (ER) & URGENT CARE FACILITY SERVICES • Hospital emergency room (ER) for a medical Emergency including emergency services as that term is defined in this document. • Use of an Urgent Care facility. • Ancillary charges (such as lab or x-ray) performed **during** the ER or Urgent care visit. • (See also the Ambulance section of this schedule.)	• If an Emergency room service is subject to a copayment per visit, the copay will be waived if subsequent immediate Hospitalization is required. • Out-of-network emergency room services are payable at the in-network level of benefits only if the treatment is for an emergency, as defined by the Plan in the Definitions chapter of this document under the heading of "Emergency Care." • If a participant is treated at an In-network ER and a treating physician is an out-of-network provider, claims are paid at the in-network level of benefits up to the Allowed Charges as that term is defined in this Plan. • There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. Also, the Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with health reform Affordable Care Act regulations. See the definition of Allowed Charge or contact the medical plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers.	**Emergency Room and physician fees associated with care in the ER:** 80% after deductible met **Urgent Care Facility:** 80% after deductible met	**Emergency Room and physician fees associated with care in the ER:** 80% after deductible met **Urgent Care Facility:** 50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network

ENTERAL THERAPY SERVICES
• Enteral nutritional therapy provides nourishment directly to the digestive tract of a person who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutritional formula is payable when medically necessary and all the following criteria are met:
  • When the formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and ALL of the following criteria are met:
  • Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements, and
  • The individual has one of the following conditions that is expected to be permanent or of indefinite duration:
  • an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel;
  • disease of the small bowel that impairs absorption of an oral diet;
  • a central nervous; or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.
	• Enteral therapy services are covered only when ordered by a Physician.
	• Coverage for a home enteral infusion pump (and associated necessary supplies) is considered payable when the use of the pump is medically necessary because the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion of the enteral formula.
	• Enteral nutritional formula that is not payable by the plan includes:
	  • standardized or specialized infant formula or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems.
	  • food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like.
	  • weight-loss foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and mineral.
		80% after deductible met	50% after deductible met

FAMILY PLANNING AND CONTRACEPTIVE SERVICES • Sterilization services (e.g., vasectomy, tubal ligation, Essure). • FDA-approved contraceptives including oral birth control pills/patches, injectables (e.g., Depo-Provera), Intrauterine devices (IUD), diaphragms, implantable birth control devices.	• See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Sexual Dysfunction Services in the Exclusions chapter. • No coverage for the diagnosis or treatment of fertility and infertility. • No coverage for the diagnosis or surgical treatment of sexual dysfunction. Coverage is provided for erectile dysfunction medications under the Outpatient Prescription Drug Benefit (e.g., Viagra, Cialis, Levitra, Muse, Caverject) to a maximum of 6 doses per person per month. • No coverage for reversal of sterilization procedures.	FDA approved Contraceptive methods and counseling, and Sterilization: 100%, no deductible. All other services: 80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
GENETIC TESTING AND COUNSELING The genetic testing payable under this Plan is for: a. state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers); b. genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see the Preventive Services row in this Schedule). c. fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee; d. tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; e. the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants who have all the following: • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and • the covered individual displays clinical features/symptoms, or is at direct risk of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and • the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being delivered to the covered individual in conjunction with a genetic test that is payable by this Plan.	• **Genetic testing noted in "c", "d" and "e" to the left, must be precertified.** See the Utilization Management chapter of this document. • Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided and provided with regard to a genetic test that is payable by this Plan. • Certain genetic testing is payable at no cost to you. See the Preventive Services row in this Schedule. • See also the definitions of Genetic Counseling and Genetic Testing in the Definitions chapter. • No coverage for pre-parental genetic testing or any other genetic testing and counseling not related to the benefits outlined to the left. See also the Exclusions chapter for exclusions relating to Genetic Testing and Counseling.	80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

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Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
HEARING BENEFITS	• See the Corrective Appliance row of this schedule.		
HOME HEALTH CARE AND HOME INFUSION SERVICES • Part-time, intermittent **Skilled Nursing Care** services and Medically Necessary supplies to provide Home Health Care or home infusion services, subject to an Annual Maximum Plan Benefit shown in the Explanations and Limitations column.	• **Home health and home infusion therapy services require precertification.** See the Utilization Management chapter of this document. • See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions chapter of this document. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner. • The Annual Maximum Benefit for Skilled Nursing Care services and supplies to provide Home Health Care, Home Infusion Services and home health aide services is **100 visits** per person per calendar year. • Home Hospice coverage is described below under Hospice benefits. Home Physical Therapy services coverage is described below under Rehabilitation Services benefits. Prescription Drugs (Medicines) coverage is described above under Drugs (Medicines) benefits.	80% after deductible met	50% after deductible met
HOSPICE • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the definition of hospice in the Definitions chapter of this document.	• **Inpatient hospice admission require precertification.** See the Utilization Management chapter of this document. • Bereavement counseling beyond that included as part of the Hospice program is payable under the Behavioral Health benefits of this Plan. • **Respite Care:** The Plan covers up to 8 days of Respite care during a Hospice benefit. Respite care may include expenses for medical services and supplies when confined in a facility maintained by a hospice agency when such confinement is for respite care to relieve the person residing with and caring for the terminally ill patient in his/her home.	80% after deductible met	Home Hospice: 50% after deductible met Inpatient Hospice: Not covered.
LABORATORY SERVICES (Outpatient) • Technical and professional fees.	• **Sleep studies (called polysomnography) and certain genetic testing (see the Genetic testing row) require precertification.** See the Utilization Management chapter of this document. • Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Certain lab testing is payable at no cost to you. See the Preventive Services row in this Schedule.	80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
MATERNITY SERVICES • Hospital and Birth (Birthing) Center charges and Physician and Midwife fees for Medically Necessary maternity services. • One routine ultrasound per pregnancy is payable. • Termination of pregnancy is covered only when the attending Physician certifies that the female Employee or Spouse's health would be endangered if the fetus were carried to term or where complications arise from an abortion. • See Genetic Testing for additional information. • The Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a qualified provider, while breastfeeding, at 100%, no deductible for all females, when provided by an in-network provider. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.	• **Prenatal and postnatal office visits, breast pump and supplies, lactation counseling and Health Reform –mandated preventive services are payable for all females with no cost-sharing when performed by an in-network provider**. • Pregnancy-related care is covered for a female Employee or Spouse only. For an employee or spouse, normal plan cost-sharing applies to all other maternity related services including an ultrasound and delivery fees. • Expenses related to a complication of a pregnancy of a Dependent Child are payable at normal cost-sharing. **No coverage is provided for delivery-related expenses of a pregnant dependent child and their newborn**. • Certain prenatal care and preventive expenses for pregnant women (as listed on the government website at http://www.hrsa.gov/womensguidelines/ or **Error! Hyperlink reference not valid.**https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to screening for gestational diabetes, breastfeeding supplies, rental of breast feeding equipment and, comprehensive lactation support and counseling by a trained provider while breastfeeding are covered under the Wellness/Preventive Services category without cost sharing from in-network providers for a female Employee, Spouse and Dependent Child. • See the exclusions related to Maternity Services in the Exclusions chapter. • See also, the Special Rule for Coverage of Newborn Dependent Children in the Eligibility chapter. • **Hospital Length of Stay for Childbirth:** The Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).	**Prenatal and postnatal office visits and Health Reform mandated preventive care:** 100%, no deductible. **Breastfeeding equipment and supplies:** See the DME row. **Breastfeeding Lactation counseling:** 100%, no deductible **All other maternity services for an Employee or Spouse including an ultrasound and professional delivery fees:** 80% after deductible met **For a pregnant dependent child** you pay 100% for certain prenatal tests like ultrasounds and delivery expenses.	**For an Employee or Spouse:** 50% after deductible met **For a pregnant dependent child** the Plan does not pay, and instead you pay expenses beyond office visits and Health Reform mandated preventive services, meaning you pay for services such as ultrasounds and delivery expenses.

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA) This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**			
Benefit Description	**Explanations and Limitations of Benefits**	**Consumer Driven Health Plan (CDHP) with HSA**	
		In-Network	**Out-of-Network**
NONDURABLE SUPPLIES Coverage is provided for: • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. • Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under the Prescription Drug Program.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter.	80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
ORAL, CRANIOFACIAL, AND TMJ SERVICES • Accidental Injury to Teeth. • Temporomandibular Joint (TMJ) dysfunction or syndrome. • Oral and/or Craniofacial Surgery. • Oral Surgery only for services noted to the right.	• See the Dental Services exclusions in the Exclusions chapter. • **Alveolar ridge reconstruction** is payable including the use of hydroxyapatite particles and inserts for augmentation of mandibular and maxillary alveolar ridges provided the Claims Administrator receives documentation of treatment for ulceration, appropriate dental x-rays and documentation that the patient has been wearing dentures for at least 10 years. • **Treatment of Accidental Injuries to the Teeth:** The Plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met: – The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and – The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and – The dental treatment will return the person's teeth to their pre-injury level of health and function. See the definition of Injury to Teeth in the Definitions chapter of this document. • **Treatment of Temporomandibular Joint (TMJ) dysfunction or syndrome is payable only if preauthorized** through the Utilization Management Company. See the Utilization Management chapter of this document. **Medically necessary surgery for TMJ syndrome/dysfunction is payable to a maximum of $5,000 per person per lifetime.** • **Oral or craniofacial surgery** is limited to cutting procedures to remove tumors/cysts. No coverage for dental services such as removal of wisdom teeth, extraction of boney impacted teeth, root canal, gingivectomy, or dental abscess treatment. • Coverage is provided by the Plan for up to $10,000 per person per calendar year to a maximum of $25,000 per person per lifetime for eligible dental services resulting from Medically Necessary **orthognathic surgery**. Coverage is payable for orthognathic surgery for the treatment of prognathism, retrognathism and other reasons if determined by the Plan Administrator or its designee to be Medically Necessary and not cosmetic.	80% after deductible met	50% after deductible met
OUTPATIENT (Ambulatory) SURGERY • Ambulatory (Outpatient) Surgical Facility or Center. • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• **Admission to an outpatient surgical facility requires precertification.** See the Utilization Management chapter for details. • Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services if the utilization management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this medical plan.	80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
PREADMISSION TESTING (Outpatient) • Laboratory tests, x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.	• Covered only when ordered by a Physician or Health Care Practitioner.	80% after deductible met	50% after deductible met
RADIOLOGY (X-Ray), NUCLEAR MEDICINE AND RADIATION THERAPY SERVICES (Outpatient) • Technical and professional fees associated with diagnostic and curative services, including radiation therapy. • One routine ultrasound per pregnancy.	• **The following tests and diagnostic procedures require precertification: Magnetic Resonance Imaging (MRI) scan, CT scan, Endoscopy, and Colonoscopy.** See the Utilization Management chapter of this document. • Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered under the Preventive Services Programs described under Wellness in this Schedule.	80% after deductible met	50% after deductible met
RECONSTRUCTIVE SERVICES AND BREAST RECONSTRUCTION AFTER MASTECTOMY • The Plan complies with the **Women's Health and Cancer Rights Act** 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.	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter. Most Cosmetic services are excluded from coverage. • Reconstructive Surgery is payable if such procedures or treatment are necessary for the repair or alleviation of damage resulting from a disability caused by accidental bodily injuries sustained by a Participant, trauma, infection or disease of the involved part or the surgery is necessary because of congenital disease or anomaly of a Dependent Child which has sustained a functional defect.	80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
REHABILITATION SERVICES (Cardiac and Pulmonary) • **Cardiac Rehabilitation** is available to individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.). • **Pulmonary Rehabilitation** is available to individuals who are able to actively participate in a Pulmonary Rehabilitation program that is likely to improve their pulmonary condition, as determined by the Plan Administrator or its designee.	• **Cardiac rehabilitation services require precertification**. See the Utilization Management chapter of this document. • Cardiac and Pulmonary Rehabilitation programs must be ordered by a Physician. • See also the Definition of Cardiac Rehabilitation in the Definitions chapter of this document.	80% after deductible met	50% after deductible met
REHABILITATION SERVICES (Occupational, Physical, and Speech Therapy) • Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.**	• **Physical and occupational therapy after three initial visits requires precertification. Inpatient rehabilitation admission requires precertification**. See the Utilization Management chapter for details. • Maintenance Rehabilitation, habilitation, and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation Therapies in the Exclusions chapter. • Rehabilitation services are covered only when ordered by a Physician. • **Speech therapy which is to last beyond two months must be precertified through the Utilization Management firm.** See the Utilization Management chapter of this document. • **Speech therapy** is covered if provided by a licensed or duly qualified speech therapist to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Speech therapy for functional purposes, (including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin) or childhood developmental speech delays and disorders are excluded from coverage.	80% after deductible met	Inpatient rehabilitation admission: Not covered. All other rehabilitation services: 50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
ROUTINE COSTS RELATED TO CLINICAL TRIALS • Routine patient costs for all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. • The Clinical Trial must be approved as a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition as more fully described by law. A life threatening condition is any disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.	• **Clinical Trial Participation is subject to precertification for the purpose of (i) determining whether you are a "qualified individual", (ii) to verify that the trial is an "approved clinical trial" within the meaning of the law and (iii) to determine whether there exists an in-network clinical trial that will accept you as a participant.** • A "qualified individual" must be eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition and either: (i) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or (ii) the individual provides medical or scientific information establishing that the individual's participation in such trial would be appropriate based upon the above conditions. • **The level of Plan coverage of routine costs will be based on whether the items or services are provided through in-network or out-of network providers. If one or more in-network providers is participating in a clinical trial the Plan requires that a qualified individual participate in the in-network provider's clinical trial if the participating provider will accept the individual as a participant in the trial.** • "Routine patient costs" do not include (i) the investigational item, device or service itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	**Routine Costs Related to your Clinical Trial Participation** Coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan.	**Routine Costs Related to your Clinical Trial Participation** Coinsurance level, deductibles and copayments for routine costs are based on the item or service as applicable in the non-clinical trial setting under the Plan.
SKILLED NURSING FACILITY (SNF) OR SUBACUTE FACILITY • Skilled Nursing Facility (SNF). • Subacute Care Facility.	• Services must be ordered by a Physician. To determine if a facility is a skilled nursing or subacute facility see the Definitions chapter of this document. • **Admission to a Skilled Nursing Facility confinement or Subacute care facility confinement requires precertification.** See the Utilization Management chapter for details. • **Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to 120 days per calendar year.**	80% after deductible met	Not covered.

SMOKING/TOBACCO CESSATION PROGRAMS
• This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco). This benefit includes:
  • Acupuncture as a treatment for tobacco cessation.
  • Low level laser therapy as a treatment for tobacco cessation.
	• Coverage is extended for programs intended to assist an individual to stop smoking or using tobacco products. This coverage includes these tobacco cessation treatment options: low level laser therapy or acupuncture. No coverage for hypnosis or massage therapy.
	• Claims for over-the-counter tobacco cessation products are able to be reimbursed by the Plan at 100% with a prescription. See the Drug row of this Schedule of Medical Benefits for information on coverage of drugs to help with tobacco cessation.
	• See the Behavioral Health Services row for information on counseling that can be used to treat a nicotine addiction.
		80% after deductible met	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
TRANSPLANTS (Organ and Tissue) • Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue and **only for the following:** heart, kidney, cornea, bone marrow, lung, liver, heart/lung, pancreas and kidney/pancreas, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Coverage includes: – charges for the live donor for removal of a donated organ/tissue for a preauthorized transplant to a Participant or, – for a Participant who is a live donor, for removal of a donated organ when the organ is one which would have been covered if the recipient were a Participant and when the recipient's insurance specifically excludes coverage for charges incurred by a donor; or – Cadaver donor expenses. • No coverage for expenses incurred by a person who donates an organ or tissue, unless the person who receives the donated organ/tissue is the person covered by the Plan.	• See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter. • **Transplant services (including pre-transplant workup tests) are subject to precertification.** See the Utilization Management chapter for details. • Donor expenses are payable to a maximum of $20,000 per person per transplant. • **Out-of-Network Transplant Maximums:** The Plan pays up to the maximums noted below: – Heart: $110,000 including a max of $20,000 for physician services. – Lung: $155,000 including a max of $20,000 for physician services. – Bone Marrow: $130,000 including a max of $20,000 for physician services. – Liver: $130,000 including a max of $20,000 for physician services – Heart/Lung: $150,000 including a max of $20,000 for physician services. – Pancreas: $70,000 including a max of $20,000 for physician services. – Kidney: $55,000 including a max of $20,000 for physician services. – Kidney/Pancreas: $95,000 including a max of $20,000 for physician services. • **Transplant Related Travel Benefit:** The Plan benefit for transplant related travel expenses, including transportation, lodging for the patient and one family member or companion is $10,000 per transplant. Reimbursement is available for round trip "coach" airfare, and up to a maximum of $200 per day for lodging received during the pre-operative work-up, transplant operation and post-transplant treatment phases. Receipts are required when submitting lodging, and travel expenses for payment consideration. The IRS allows $50 per day to be received on a tax free basis. Any amounts in excess of $50.00 per day will be treated as taxable income to the employee and the Plan Administrator will be responsible for preparing a 1099 to report that income. – The following expenses will not be reimbursed by the Plan: meals, car rentals, telephone calls, personal care items such as shampoo, entertainment/recreation or personal pleasure expenses, alcohol/tobacco, souvenirs and expenses for persons other than the patient and his/her designated family member/travel companion.	80% after deductible met	50% after deductible met up to the maximums noted to the left under Explanations
VISION SERVICES		See the chapter on the Vision Plan.	See the chapter on the Vision Plan.

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
WELLNESS - PREVENTIVE SERVICES PROGRAM: WELL CHILD EXAMINATIONS AND IMMUNIZATIONS • Outpatient newborn and well child visits and routine childhood immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"), including flu shots. • Wellness and preventive services are payable as listed on the websites shown in the column to the right. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • For children age 6 years and older with obesity, the Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's network pediatrician. • Performed in primary practices, **topical fluoride** varnish to the primary teeth of children through age 5 years. • In this section and the following section on Preventive Services the term "cost-sharing" is used to refer to costs you would pay under the Plan, such as deductibles, coinsurance and copayments. • If the Plan does not have in its network a provider who can provide a particular required preventive service, then the Plan will cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.	The preventive services payable by this plan (without cost-sharing on your part) are designed to comply with Health Reform regulations. With respect to infants, children and adolescents, evidence-informed preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) are covered as well as immunizations for routine use in children, and adolescents that are recommended by the Advisory Committee on Immunization Practices (ACIP). For complete and up-to-date information see https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. In addition to the wellness/preventive services listed on the websites here, the Plan will pay for well child office visits. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services. • When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance and deductible) will apply to the diagnostic or therapeutic services provided. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. Services not covered under the Preventive Services wellness benefit may be covered under another portion of the medical plan. • If your in-network health care provider prescribes a vaccine consistent with the ACIP recommendations, the Plan will provide coverage without cost-sharing. New ACIP recommendations will be covered without cost-sharing starting with the Plan year that begins on or after the date that is one year after the date the recommendation is issued. • See the Special Rule for Coverage of Newborn Dependent Children in the Eligibility chapter. • See the exclusion of expenses for physical examinations and testing required for school, camp, recreation, sports, etc., in the Exclusions chapter.	100% no deductible.	50% after deductible met

SCHEDULE OF MEDICAL BENEFITS FOR THE CONSUMER DRIVEN HEALTH PLAN (CDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

This chart explains the benefits payable by the Plan. **All benefits are subject to the deductible** except where noted. See also the Exclusions and Definitions chapters of this document for important information. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations of Benefits	Consumer Driven Health Plan (CDHP) with HSA	
		In-Network	Out-of-Network
WELLNESS - PREVENTIVE SERVICES PROGRAM: ADULT HEALTH MAINTENANCE EXAMINATIONS (for Active Employees, their Spouse and Dependent Children as appropriate) including: • Complete history and physical examination; x-ray charges for chest x-ray; routine screening mammogram; annual gynecology exam for purpose of obtaining a pap smear; laboratory charges for complete blood count, urinalysis, pap smear, and prostate blood test (PSA); screening colonoscopy; CDC-recommended immunizations including flu shots. See also Well Child Examinations and Immunizations . • Preventive Services consist of 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 ("USPSTF") with respect to the individual involved. Preventive Services also includes immunizations for routine use in adults that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"). • With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") to the extent not already included in certain recommendations of the USPSTF. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • If any recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a service, the Plan will use reasonable medical management techniques to determine any coverage limitations. • The Plan recognizes that certain USPSTF recommendations apply to certain individuals identified as "high-risk" due to factors such as family or personal history of disease. Therefore, if the attending provider determines that a patient belongs to a high-risk population and a USPSTF recommendation applies to that high-risk population, any preventive item or service recommended by the USPSTF in connection with such high-risk individual will be covered without cost-sharing subject to reasonable medical management. • If the Plan does not have in its network a provider who can provide a particular required preventive service, then the Plan will cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.	The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). These websites list the types of payable preventive services (such as immunizations, mammogram, pap smear, and screening colonoscopy): https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. In addition to the Preventive Services listed on the website above, the Plan will pay for these Preventive Services: an annual (although in some circumstances several visits may be necessary depending on health factors) wellness/physical exam for adults, annual prostatic specific antigen (PSA) lab test for men, screening mammogram for women at any age, chest x-ray, EKG. complete blood count and urinalysis. A screening colonoscopy (including anesthesia) is payable for participants age 50 years and older once every five years. • For people with certain health conditions, over-the-counter ("OTC") medications may be recommended by their health care provider, When OTC medications are recommended by the USPSTF and prescribed by your health care provider the Plan will cover such OTC medications without cost-sharing. Contraceptive methods must be FDA-approved and prescribed for a woman by her health care provider. The HRSA guidelines do not include contraception for men. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. Under certain circumstances as stated in regulatory guidance, some procedures, such as polyp removal during a screening colonoscopy are considered an "integral part" of the preventive service. In these circumstances the Plan will not impose cost- sharing on you. However, the Plan will impose cost- sharing for a treatment that is not a recommended preventive service even if the treatment results from a recommended preventive service. • For women's preventive services, genetic counseling and an evaluation for routine breast cancer susceptibility gene (BRCA) may include without cost-sharing the BRCA test itself, if appropriate, as determined by your health care provider. • **Women's Preventive Services:** HRSA Guidelines recommend at least one annual well-woman preventive care visit for adult women to obtain the recommended preventive services without cost-sharing that are age and developmentally appropriate including preconception and prenatal care. Additional preventive care visits (without cost-sharing but subject to reasonable medical management) may be necessary depending on a woman's health status, health needs and other risk factors as determined by the clinician .HRSA guidelines recommend annual HIV counseling and screening (which includes testing) for sexually active adult women and high-risk HPV DNA testing every three years for women as age and risk appropriate. HRSA Guidelines ensure women's access to the full range of FDA-approved contraceptive methods. However, the Plan will impose cost-sharing for brand name contraceptive drugs or other pharmacy products when a generic drug is available subject to medical appropriateness as determined by the individual's health care provider. Services related to follow-up and management of contraceptive side effects, counseling for continued adherence and device removal are covered without cost-sharing and subject to reasonable medical management. Comprehensive prenatal and postnatal lactation support, breastfeeding counseling and lactation equipment rental or, if appropriate, purchase, are covered for the duration of breastfeeding without cost-sharing and subject to reasonable medical management. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency and method to the extent not specified in a recommendation or guideline. Services not covered under the wellness benefit may be covered under another portion of the medical plan. • If your in-network health care provider prescribes a vaccine consistent with the Advisory Committee on Immunization Practices (ACIP) recommendations, the Plan will provide coverage without cost-sharing. New ACIP recommendations will be covered without cost-sharing starting with the Plan year that begins on or after the date that is one year after the date the recommendation is issued.	100%, no deductible.	50% after deductible met

6. UTILIZATION MANAGEMENT (UM)

PURPOSE OF THE UTILIZATION MANAGEMENT (UM) PROGRAM:

Your Plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the Fund to afford the cost of maintaining your plan.

To enable the Fund to provide coverage in a cost-effective way, your Plan has adopted a utilization management program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its benefits.

If you follow the procedures of the Plan's utilization management program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, the Fund provides reduced benefits, and you'll be responsible for paying more out of your own pocket.

MANAGEMENT OF THE UTILIZATION MANAGEMENT PROGRAM:

The Fund's Utilization Management Program is administered by independent professional Utilization Management Companies operating under a contract with the Fund (hereafter referred to as the UM Company, Prescription Drug Program and the Behavioral Health Program). The name, address and telephone number of the UM Company, Prescription Drug Program and the Behavioral Health Program appears in the Quick Reference Chart in the Introduction chapter of this document.

The health care professionals in the UM Company, Prescription Drug Program and the Behavioral Health Program focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical, behavioral health or surgical services.

In carrying out its responsibilities under the Plan, the UM Company, Prescription Drug Program and the Behavioral Health Program have been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

ELEMENTS OF THE UTILIZATION MANAGEMENT PROGRAM:

The Fund's Utilization Management Program consists of:

1. **Precertification (or Pre-service) review:** review of proposed health care services before the services are provided;
2. **Concurrent Review:** the review of the confinement while a Participant is confined in a hospital or other recognized facility on an inpatient basis. The review of the continued stay in the facility is coordinated with the Physician, the facility and the Review Coordinator for determining Medically Necessary care. The review is designed to eliminate unnecessary treatment or unneeded prolonged confinements. Concurrent reviews also include any request to extend the duration or number of treatments approved during a pre-service review.
3. **Retrospective (or Post-Service) review:** review of health care services after they have been provided; and
4. **Case Management:** the review of certain claims by the Review Coordinator to ensure the quality of medical care in a hospital or health care facility and to provide care and treatment in a less expensive setting or manner. The Review Coordinator has the right to review alternative methods of medical care or treatment not otherwise considered as a covered charge by the Fund. The committee reserves the right to require medical case management for certain claims.

RESTRICTIONS AND LIMITATIONS OF THE UTILIZATION MANAGEMENT PROGRAM, PRESCRIPTION DRUG PROGRAM AND THE BEHAVIORAL HEALTH PROGRAM (Very Important Information):

1. The fact that your Physician recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be considered Medically Necessary for determining coverage under the Medical Plan.
2. The Utilization Management Program, the Prescription Drug Program, and the Behavioral Health Program are not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's, Prescription Drug Program's or the Behavioral Health Program's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

3. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if:
   - the UM Company, Prescription Drug Program, and the Behavioral Health Program do not certify a proposed Surgery or other proposed medical treatment as Medically Necessary; or
   - the Fund will not pay regular Plan benefits for a Hospitalization or confinement in a Health Care Facility because the UM Company, Prescription Drug Program or the Behavioral Health Program does not certify a proposed confinement; the benefits payable by the Plan may, however, be affected by the determination of the UM Company, Prescription Drug Program or the Behavioral Health Program.
4. With respect to the administration of this Fund, the Employer, the Plan and the UM Company, Prescription Drug Program, and the Behavioral Health Program are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company, Prescription Drug Program or the Behavioral Health Program as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM Company, Prescription Drug Program or the Behavioral Health Program as Medically Necessary.
5. Precertification of a service does not guarantee that the Plan will pay benefits for that service because, other factors, such as ineligibility for coverage on the actual date of service, may be a factor in non-payment of a service.

PRECERTIFICATION (OR PRE-SERVICE) REVIEW

6

How Precertification Review Works: Precertification Review is a procedure, administered by the UM Company or the Behavioral Health Program for medical and surgical services and the Behavioral Health Program for inpatient mental health and substance abuse services, or the Prescription Drug Program for outpatient prescription drug services, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary.

The names and phone numbers of the UM Company, Prescription Drug Program, and Behavioral Health Program are listed on the Quick Reference Chart in the Introduction chapter of this document.

What Services Must Be Precertified by the UM Company (Approved Before They Are Provided)

1. All inpatient hospital admissions.
   NOTE: Precertification is required for pregnant women with hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery or 96 hours for a C-section delivery.
2. Admission to a residential treatment program, skilled nursing facility, subacute care facility, inpatient hospice or inpatient rehabilitation facility.
3. Transplant services (including pre-transplant workup tests).
4. Physical therapy and/or occupational therapy services after the first three visits.
5. Speech therapy that will last beyond two months.
6. Outpatient surgery in a hospital or licensed ambulatory surgical facility.
7. Endoscopies and colonoscopies.
8. Medical Resonance Imaging (MRI) and Computerized Tomography (CT) scans.
9. Continuous Positive Airway Pressure (CPAP) Equipment.
10. Temporomandibular Joint (TMJ) treatment.
11. Cardiac Rehabilitation.
12. Sleep study (called polysomnography).
13. Home health care.
14. Prosthetic Devices.
15. Intravenous (IV) iron therapy.
16. Non-emergency medical transportation services.
17. Certain genetic testing as outlined in the Genetic Services row of the Schedule of Medical Benefits.
18. For individuals who plan to participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an “approved clinical trial” and notify the Plan’s claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
19. Administration of a class of drugs called “survival motor neuron-2 (SMN2)-directed antisense oligonucleotides,” which includes drugs such as Spinraza (nusinersen).

What Services Must Be Precertified by the Behavioral Health Program (Approved Before They are Provided)

1. All inpatient hospital admissions for mental/nervous disorders or substance abuse treatment.

What Drugs Must be Precertified by the Prescription Drug Program (Approved Before they are Filled)

1. Certain classes of drugs require precertification such as Specialty Drugs, Retin A for individuals over age 26, etc.

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

There is no requirement to precertify the use of a hospital-based emergency room visit.

How to Request Precertification:

You or your Physician must call the appropriate Utilization Management Company, or the Behavioral Health Program or the Prescription Drug Program at their telephone number shown on the Quick Reference Chart in the Introduction chapter of this document.

- **Calls for Elective services should be made at least seven (7) days before the expected date of service.**
- The caller should be prepared to provide all of the following information: the Employer's name, Employee's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
- If additional information is needed, the UM Company or the Behavioral Health Program or the Prescription Drug Program will advise the caller. The UM Company or the Behavioral Health Program or the Prescription Drug Program will review the information provided, and will let you, your Physician and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. The UM Company or the Behavioral Health Program or the Prescription Drug Program will usually respond to your treating Physician or other Health Care Provider **by telephone within three (3) working days after it receives the request and any required medical records and/or information, and its determination will then be confirmed in writing**.
- If your admission or service is determined not to be Medically Necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal. See also the section of this chapter regarding Appealing a UM Determination.

CONCURRENT (Continued Stay) REVIEW

How concurrent (continued stay) review works: When you are receiving medical services in a hospital or other inpatient health care facility, the UM Company or the Behavioral Health Program will monitor your stay by contacting your physician or other health care providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your physician or other health care providers of various options and alternatives for your medical care available under this Plan.

If at any point your stay is found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay was not Medically Necessary, no benefits will be paid on any related hospital, medical or surgical expense.

EMERGENCY HOSPITALIZATION

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

RETROSPECTIVE (or Post-Service) REVIEW

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

CASE MANAGEMENT

How Case Management Works: Case management is a process, administered by the UM Company. Its medical professionals work with the patient, family, caregivers, health care providers, claims administrator and the Fund to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers. See the section titled restrictions and limitations of the utilization management program in this chapter.

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

The Case Manager of the UM Company will work directly with your Physician, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Health Care Providers as needed. From time to time, the Case Manager may confer with your Physician or other Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services. You, your family, or your Physician may call the Case Manager at any time at the telephone number shown on the Quick Reference Chart in the Introduction chapter of this document to ask questions, make suggestions, or offer information.

APPEALING A UM DETERMINATION (Appeals Process)

You may request an appeal of any adverse review decision made during the precertification, concurrent review, retrospective review, or case management process described in this chapter. To appeal an adverse benefit decision made by the UM Company, Prescription Drug Program or the Behavioral Health Program, refer to the Claims Filing and Appeals Information chapter in this document.

FAILURE TO FOLLOW REQUIRED UTILIZATION MANAGEMENT PROCEDURES
(Very Important Information)

If you don't follow the Precertification Review procedures described in this chapter, you will be penalized by having to pay **a penalty of $200**. Note that this penalty **will not count toward meeting the Plan's Deductible or Annual Out-of-Pocket Maximum.** This penalty does not apply to precertification of prescription drugs. In addition, you take the risk that your procedure or treatment is determined to be not Medically Necessary in which case the Plan will not pay any benefits.

7. MEDICAL PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered by any of the Medical Plan options**. If a service or supply is not specifically listed as being covered, it should not be construed to mean that the service or supply is covered. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

GENERAL EXCLUSIONS (applicable to all medical services and supplies)

1. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. **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, photocopying fees, concierge/retainer agreement/membership fees, disabled person license plates/automotive forms, interest charges, late fees, and mileage costs.
3. **Educational Services:** Expenses for educational services, supplies or equipment, including, but not limited to private or public school expenses, computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, special education, etc., even if they are required because of an injury, illness or disability of a Covered Individual.
4. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by your Employer.
5. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation, or Annual Maximum Plan Benefits, as described in the Schedule of Medical Benefits chapter of this document.
6. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions chapter of this document.
7. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. Expenses for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Liability in the chapter on Coordination of Benefits in this document for an explanation of the circumstances under which the Fund will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
8. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical, dental and vision plans; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
9. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
10. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
11. **Illegal Act:** To the extent legally permitted including but not limited to the source of injury guidelines, expenses incurred by any Covered Individual for injuries and/or illness resulting from or sustained as a result of, or in any way connected to, the commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator or its designee determines in its sole discretion, including but not limited to any misdemeanor or felony behavior; an illegal act shall be presumed if any action involves force or violence or the threat of force or violence by the Covered Individual or to another person or an act in which a firearm, explosive, weapon or instrument likely to or capable of causing physical harm or death is used by the Covered Individual. The Plan Administrator's or its designee's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
12. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.
13. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification

of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc.

14. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
15. **No Physician Prescription:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician or Health Care Practitioner.
16. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual, unless those travel expenses are related to a plan approved transplant as outlined under Transplants in the Schedule of Medical Benefits.
17. **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.
18. **Personal Comfort Items:** Expenses for patient convenience, comfort, hygiene or beautification, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, DVD/Compact Disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

19. **Physical Examinations, Tests for Employment, School, etc.:** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party. See however the wellness benefits payable under Preventive Services Programs in the Wellness row of the Schedule of Medical Benefits.
20. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee.
21. **Medical Students or Interns:** Expenses for the services of a medical student or intern.
22. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.
23. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency (as defined in the Definitions chapter of this document).
24. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.
25. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.
26. **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation: Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.
27. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.
28. **Services related to a Court Order:** Expenses for or related to examinations, reports or appearances in connection with legal proceedings or accommodations pursuant to a court order, whether or not a sickness or accidental injury is involved, **unless** the services requested are determined by the Plan Administrator or its designee to be Medically Necessary and are a covered benefit under the Plan.

29. **State Surcharges:** Any surcharges a Participant incurs as a result of state laws (e.g., New York Health Care Reform Act, Massachusetts Uncompensated Care Pool Surcharge).

30. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

31. **Specifically Identified Providers and/or Facilities:** Regarding implementing a reasonable medical management technique with respect to the frequency, method, treatment or setting for care, all non-emergency services, supplies or other expenses for consultation, care or treatment of any injury, sickness, illness, disease or preventive services at or by the following providers and/or facilities (notwithstanding any other provision or term or condition in the Plan) are not covered: Cancer Treatment Centers of America (CTCA) and related providers and affiliates.

32. Expenses for **halfway house, wilderness therapy program**, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care, group home.

33. Expenses for tests to determine the presence of or degree of a person's attention deficit disorder, dyslexia or learning disorder.

34. Expenses for **hypnosis**, hypnotherapy and/or biofeedback.

35. Expenses for services related to **adoption counseling**; attention deficit disorders (without hyperactivity). Expenses for tests to determine the presence of or degree of a person's attention deficit disorder, dyslexia or **learning disorder**. Note marital/family counseling is available through the EAP services discussed under Behavioral Health in the Schedule of Medical Benefits.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

A. **Alternative/Complementary Health Care Services Exclusions**
   1. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
   2. Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner.
   3. Expenses for naturopathic, naprapathic and/or homeopathic treatments/supplies.

B. **Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions**
   1. Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions chapter of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners.
   2. Expenses for **replacement of lost, missing, or stolen**, **duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment, except that replacement or repair of a prosthetic device is payable once in a five-year period provided prior authorization has been obtained from the Utilization Management Company.
   3. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
   4. Expenses for occupational therapy **(orthotic) supplies and devices** needed to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing, shower bench, and raised toilet seat.
   5. Expenses for **nondurable supplies,** except as payable under Nondurable Supplies in the Schedule of Medical Benefits.
   6. Corrective shoes or supportive devices for the feet including orthotics unless they are an integral part of a lower body brace.

C. **Cosmetic Services Exclusions**
   1. Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. Plan Participants should use the Plan's Precertification procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery.

D. **Custodial Care Exclusions**

1. Expenses for Custodial Care as defined in the Definitions chapter of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, personal care, sitter/companion service, assisted living arrangements, memory care, or senior care facility/program.
2. Services required to be performed by Physicians, Nurses or other Skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are Medically Necessary.

E. **Dental Services Exclusions**

1. Expenses for **Dental Prosthetics or Dental services or supplies** of any kind, even if they are necessary because of symptoms, illness or injury affecting the mouth or another part of the body, unless certain conditions noted below apply. See also the Dental benefits noted in the Dental Plan chapter in this document available to Participants enrolled in the Premium Health Plan, Premium Plus Plan and the Comprehensive Health Plan. Expenses for Dental Prosthetics and Dental services may be covered under the Medical Plan only if they are incurred:
   a. For the repair or replacement of Accidental Injury to the Teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Fund, an accident does not include any injury caused by biting or chewing.
   b. As a result of a congenital malformation/defect.

   See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits for additional information. For assistance in determining if certain dental services are payable under the Medical Plan contact the Administrative Office.
2. Expenses for the medical or surgical **treatment of Temporomandibular Joint (TMJ) Dysfunction or Syndrome, unless** approved via the preauthorization process described in the Utilization Management chapter of this document.
3. Expenses for upper and lower jaw augmentation or reductions procedures (**Orthognathic services/surgery)** for treatment of Prognathism, Retrognathism and other reasons determined by the Plan Administrator or its designee to be cosmetic and not Medically Necessary.
4. Expenses for **oral surgery** for gingivectomies, treatment of dental abscesses, extraction of boney impacted teeth, and root canal (endodontic) therapy.

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

1. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e., are used "off-label"); or are Experimental and/or Investigational as defined in the Definitions chapter of this document. The Board of Trustees may exercise its discretion on appeal (by the participant) to waive the off-label exclusion where the Board finds upon clear and convincing evidence that (1) the prescribed pharmaceutical shows demonstrable benefit to the participant, (2) the appropriate utilization manager supports the off-label use of the pharmaceutical and (3) determines that the cost-saving benefit to the off-label use exceeds expected expenses in the absence of such use.
2. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin and certain over-the-counter(OTC) medication prescribed by a Physician or Health Care Practitioner, or drugs covered without cost-sharing in accordance with Health Reform regulations.
3. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs, minerals or medical foods for persons with inherited metabolic disorders (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during a covered Hospitalization and benefits for Enteral Therapy as described in the Schedule of Medical Benefits.
4. Naturopathic, naprapathic or homeopathic substances.
5. Drugs, medicines or devices for:
   - Cosmetic drugs such as Renova and depigmenting agents;
   - Desi drugs (drugs determined by the Food and Drug Administration to lack effectiveness);
   - Non-prescription male contraceptives;
   - Fertility and/or infertility;
   - Dental products such as fluoride preparations and products for periodontal disease, except when prescribed by a Physician or Health Care Practitioner, or as covered without cost-sharing in accordance with Health Reform regulations;
   - Hair removal or hair growth products (i.e., Propecia, Rogaine, Minoxidil, Vaniqa);
   - Vitamins including prenatal vitamins, except when prescribed by a Physician or Health Care Practitioner, or as covered without cost-sharing in accordance with Health Reform regulations;
   - Vitamin A derivatives (tretinoin/retinoids) for dermatologic use (i.e., Retin A, Renova) for patients age 26 and older;

- Weight control or anorexiants, except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.
- Drug treatment of female hypoactive sexual desire disorder (HSDD) (e.g. prescription drugs such as Addyi).

6. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal law.
7. Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility.
8. Vaccinations, immunizations, inoculations or preventative injections, except those provided under Preventive Services Programs for children and/or adults (see the Wellness row of the Schedule of Medical Benefits), and those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin).

G. **Durable Medical Equipment Exclusions**

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

H. **Fertility and Infertility Services Exclusions**

1. Expenses for the diagnosis of and medical or surgical treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures.

I. **Foot/Hand Care Exclusions**

1. Expenses for routine foot care, (including but not limited to trimming of toenails, removal of callouses, preventive care with assessment of pulses, skin condition and sensation) or treatment of chronic conditions of the foot such as weak or fallen arches, flat or pronated foot metatarsalgia or foot strain, or hand care including manicure and skin conditioning. Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

J. **Genetic Testing and Counseling Exclusions**

1. **Genetic Testing:** The following expenses for genetic tests are not covered, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics. (Certain genetic tests are covered as listed in the Genetic Testing row in the Schedule of Medical Benefits.) Genetic services that are **not covered** include:
   a. **Pre-parental genetic testing** (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children);
   b. Expenses for **Pre-implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
   c. No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the treatment of a covered plan participant;
   d. **Home genetic testing kits/services** are not covered.

   See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan.

   Plan Participants can contact the Medical Plan Claims Administrator for assistance in determining if a proposed Genetic Test will be covered or excluded.

2. **Genetic Counseling:** Expenses for genetic counseling are not covered, unless these three conditions are met: is ordered by a Physician, performed by a qualified genetic counselor and performed in conjunction with a genetic test that is payable by this Plan.

K. **Hair Exclusions**

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

L. **Hearing Care Exclusions**

1. Special education and associated costs in conjunction with sign language education for a patient or family members.

M. **Home Health Care Exclusions**

1. Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies.

2. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, custodial care, childcare, adult care, caregiver or personal care attendant, except as provided under the Plan's Hospice coverage.

N. **Maternity/Family Planning Exclusions**

1. **Adoption expenses or birth expenses of an adopted child(ren)**.
2. Expenses related to **non-prescription male contraceptive drugs and devices** such as condoms.
3. **Termination of Pregnancy:** Expenses for elective termination of pregnancy (abortion) unless attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or where complications arise from an abortion.
4. **Home Delivery:** Expenses for pre-planned home delivery.
5. Expenses related to **ultrasounds and delivery expenses associated with a pregnant Dependent Child,** except that complications of the pregnant Dependent Child will be payable. See the definition of "Complications" in the Definitions chapter. See the Maternity row in the Schedule of Medical Benefits.
6. Expenses for **childbirth education and Lamaze classes**.
7. **Expenses related to the surrogate mother's pregnancy, delivery and complications.**
8. **Expenses related to cryostorage of umbilical cord blood or other tissue or organs.**

O. **Nursing Care Exclusions**

1. Expenses for services of private duty nurses.

P. **Prophylactic Surgery or Treatment Exclusions**

1. Expenses for prophylactic medical, surgical and prescription drug treatment is generally not a payable benefit. Prophylactic/Preventive Services will be covered if they meet the Preventive Services Program described in the Wellness row of the Schedule of Medical Benefits (such as preventive immunizations). The following prophylactic/preventive services could be covered if precertified as medically necessary by the Utilization Management firm: prophylactic mastectomy (removal of breast), prophylactic oophorectomy (removal of ovary) or prophylactic hysterectomy (removal of uterus).

   While precertification is not a guarantee of payment of benefits, Plan Participants should use the Plan's Precertification procedure to determine if a proposed service is considered Prophylactic.

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

1. Expenses for educational, job training, vocational rehabilitation, and/or special education such as sign language, etc.
2. Expenses for massage therapy, rolfing and related services.
3. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and services.
4. Expenses for Maintenance Rehabilitation as defined in the Definitions chapter of this document.
5. Expenses for speech therapy unless required to restore to function speech loss or impediments due to illness or injury.
6. Expenses for treatment of delays in childhood speech development unless as a direct result of an injury, surgery or result of a covered treatment.
7. Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired) including treatment of delays in childhood speech and physical development, even if the delay in development is a direct result of an injury, surgery or as a result of a treatment that is the type that is covered by this Plan.

R. **Sexual Dysfunction Services Exclusions**

1. **Treatment of Sexual Dysfunction**: Expenses for the diagnosis or surgical treatment of sexual dysfunction and any complications thereof. Note that medication to treat erectile dysfunction is payable under the Outpatient Prescription Drug benefit in the Schedule of Medical Benefits chapter.
2. **Sex Change Counseling, Therapy and Surgery:** Expenses for medical, surgical or prescription drug treatment related to transsexual (sex change) procedures, or the preparation for such procedures, or any complications thereof.

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

1. Expenses for human organ and/or tissue transplants that are not mentioned as covered (under Transplantation in the Schedule of Medical Benefits) or are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post operative services and drugs or medicines, and all complications thereof.

2. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.
3. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except heart valves and kidney dialysis.
4. For plan participants who serve as a donor, donor expenses are not payable by this Plan unless the person who receives the donated organ/tissue is the person covered by this Plan.

T. **Vision Care Exclusions**

1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In Situ Keratomileusis (LASIK).
2. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except as provided by the Vision Plan (and described in a separate chapter of this document).
3. Vision therapy (orthoptics) and supplies.
4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.
5. Expenses related to the treatment of contact lens intolerance.

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

1. Expenses for medical or surgical treatment of obesity, including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, skin reduction procedures/treatment, and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying health condition. This exclusion does not apply to the extent that it constitutes screening and counseling for obesity or otherwise qualifies under the Preventive Services Program category (see the Wellness row of the Schedule of Medical Benefits).
2. Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.
3. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services, exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers.

8. DENTAL PLAN

Dental Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA.
A separate election or opt out is required for dental benefits and dental plan
premiums are adjusted for individuals that opt in or out of coverage.

The Dental Plan includes a dental network, a national network of dental providers who extend a discount to you for covered dental services. Covered expenses are noted in the Schedule of Dental Benefits in this chapter and refer to the Allowed Charge for covered services up to the maximum allowed as payable under this Dental Plan.

DENTAL NETWORK

- **Network Providers:** Network providers (licensed dental hygienists and dentists) have a contract to provide discounted fees to you for services covered under this Dental Plan. By using the services of an in-network dental provider (both Preferred PPO providers and Premier providers) you and the Fund pay less. A current list of network dental providers is available free of charge when you call the Dental Plan whose name, address and telephone number are listed on the Quick Reference Chart in the front of this document. To receive services, simply call a network dental provider and identify yourself as a member of this Dental Plan.
- **Non-Network Providers:** Services may be received from any licensed dentist or dental hygienist; however, this Plan will pay at the non-network benefit level (see the Coinsurance chart in this chapter). The itemized bill reflecting the non-network provider's fees must be submitted to the Dental Plan Claims Administrator for reimbursement. You will be reimbursed according to the Allowed Charge as determined by the Dental Plan. Non-network provider services may cost you more than if those same services were obtained from an in-network provider. Non-network is also referred to as "Out-of Network."

CONDITIONS UNDER WHICH DENTAL PLAN BENEFITS ARE PROVIDED

A Covered Individual may elect the service of any Dentist, but the Dental Plan does not guarantee the availability of any particular Dentist.

ANNUAL MAXIMUM DENTAL PLAN BENEFITS

The Annual Maximum Dental Plan Benefits payable for any individual covered under this Dental Plan (except for Diagnostic, Preventive and Orthodontic benefits) is **$2,000 per person per calendar year.** This maximum does not include your deductible or any amounts over the approved amount.

ORTHODONTIA LIFETIME MAXIMUM PLAN BENEFITS

The Overall Maximum Plan Benefits payable for Orthodontia services for any individual covered under this Dental Plan is **$2,000.**

TRANSITION OF CARE PROVISION FOR ORTHODONTIC TREATMENT IN PROGRESS

This Plan honors a period for transition of orthodontic treatment for participants who are newly enrolled in the Fund because of a merger of funds. This allows these new participants to gradually transition their orthodontic care from an out-of-network provider to an in-network provider or to continue treatment with the out-of-network provider until treatment ends (or until the lifetime maximum has been paid).

Benefits for orthodontic treatment that began with an out-of-network provider prior to the transition are payable at 50% of Allowed Charge up to the lifetime maximum benefit of $2,000. Any orthodontic benefit paid under the prior plan will apply against the $2,000 lifetime maximum benefit.

DEDUCTIBLES

Each calendar year, you are responsible for paying all your Eligible Dental Expenses until you satisfy the annual Deductible. Then, the Plan begins to pay benefits. There are two types of Deductibles: Individual and Family.

- The Individual Deductible is the maximum amount one Covered Individual has to pay each Calendar Year before Plan benefits begin. **The Plan's Individual Deductible is $50.**
- The Family Deductible is the maximum amount that a family of three or more has to pay each Calendar Year before Plan benefits begin. **The Plan's Family Deductible is $150.**

Note that Eligible Dental Expenses incurred for Diagnostic and Preventive Services and Orthodontia Services are not subject to Deductibles.

COINSURANCE

Once you've met your annual Deductible, the Plan pays a percentage of the Eligible Dental Expenses, and you are responsible for paying the rest.

The Dental Plan shall pay or otherwise discharge the applicable percentage of the lesser of fees actually charged or the Allowed Charge for covered services.

PREDETERMINATIONS

Your Dentist may submit an Attending Dentist's Statement (ADS) before treatment, listing the services he wants to provide and requesting a Predetermination. A Predetermination states what benefits are payable for the listed services under the terms of the program. The Dental Plan (whose address and phone number are listed on the Quick Reference Chart in the front of this document) will issue a Predetermination for the maximum of 60 days if the patient is eligible. Once the services are completed your Dentist should again submit the Attending Dentist Statement (ADS), this time for payment of benefits.

COINSURANCE PERCENTAGE PAYABLE UNDER THE DENTAL PLAN

Subject to the limitations and exclusions described in this chapter, the following services are benefits when provided by a Dentist and when necessary and customary, as determined by the standards of generally accepted practice.

	Dental Plan Preferred Dentist (Delta Dental PPO)	Delta Dental Premier Dentist	Non-Participating Non-Delta Dentist (Out-of-Network)
Diagnostic and Preventive *(no deductible applies)*	100%	100%	70%
Basic Benefits	90%	80%	50%
Restorative Repairs	90%	80%	50%
Denture Repairs	90%	80%	50%
Crowns, Jacket & Cast Restoration	60%	50%	30%
Prosthodontic Benefits	60%	50%	30%
Orthodontic Benefits *(no deductible applies)*	50%	50%	30%

Services rendered by a non-participating Dentist outside the service area will be reimbursed by the Plan at the Participating Dentist reimbursement level.

DENTAL CLAIMS AND APPEALS

Claims for Dental services should be submitted to the Dental Plan whose name and address are listed on the Quick Reference Chart in the front of this document. You may appeal a dental claim denial by following the post-service process described in the Claim Filing and Appeals Information chapter of this document.

SCHEDULE OF DENTAL BENEFITS

The Dental Plan shall pay or otherwise discharge the applicable percentage of the lesser of fees actually charged or the Allowed Charges for the following covered services.

9. SCHEDULE OF DENTAL BENEFITS

LIMITATIONS TO ALL CATEGORIES UNDER THE DENTAL PLAN

- If a Covered Individual selects a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, the Dental Plan will pay the applicable percentage of the lesser fee and the patient is responsible for the remainder of the Dentist's fee. Alternate treatment plans must be pre-approved by the Dental Plan. Examples are: a crown where a filing could restore the tooth, a precision denture where a standard denture could suffice.
- Eligible Dental Expenses incurred for Preventive and Diagnostic Services and Orthodontia Services are not subject to the Dental Plan Deductible.

DENTAL PLAN BENEFITS	LIMITATIONS
DIAGNOSTIC AND PREVENTIVE BENEFITS • Deductible does not apply. • **Diagnostic:** Procedures to assist the Dentist in determining required dental treatment. • **Preventive:** – prophylaxis (cleaning); – topical application of fluoride solutions; – space maintainers; – topical applied acrylic, plastic or composite materials (sealants) used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay.	Diagnostic and preventive benefits are limited as follows: a. Routine oral examinations and prophylaxis treatments are provided three times in a calendar year while the patient is a Covered Individual under any Dental Plan provided by the Plan. b. Unless special need is shown, full mouth x-rays are provided only after two years have elapsed following any prior provision of full mouth x-rays under any Dental Plan provided by the Plan. Supplementary bitewing (individual) x-rays are provided on request by the dentist, but not more than once every six months while the patient is a Covered Individual under any Dental Plan provided by the Plan. c. Topical application of fluoride solutions is limited to Covered Individuals to age 19. d. Sealant Benefits are limited to Covered Individuals to age 19. e. Sealant Benefits include applications of sealants only to permanent posterior molar teeth with no caries (decay), no restorations and with the occlusal surface intact. f. Sealants are limited to one per tooth during the patient's lifetime.
BASIC BENEFITS • **Oral Surgery:** Extractions and certain other surgical procedures, including pre-and post-operative care. • **General Anesthesia:** When administered by a Dentist for a covered Oral Surgery procedure. • **Endodontic:** Treatment of the tooth pulp. • **Periodontic:** Treatment of gums and bones supporting teeth. • **Restorative:** Amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth surface resulting from the process of dental decay). • **Denture Repairs:** Repairs to partial or complete dentures including rebase procedures and relining.	
CROWNS AND CAST RESTORATIONS	Crowns and cast restorations are limited as follows: • Crowns and Cast Restorations will be covered only after five years have elapsed following any prior provision under any Dental Plan sponsored by the Plan.

DENTAL PLAN BENEFITS	LIMITATIONS
ORTHODONTIC BENEFITS • Payable to a maximum of $2,000 per person per lifetime. • Deductible does not apply.	Orthodontic benefits are limited as follows: a. All payments shall be on a monthly basis. The obligation of the Dental Plan to make periodic payments for an orthodontic treatment plan begun prior to the eligibility date of the patient shall commence with the first payment due following the patient's eligibility date. b. The obligation of the Dental Plan to make periodic payments for orthodontic treatment shall terminate on the next payment due date following the date the patient loses eligibility. c. The Dental Plan will not make any payment for repair or replacement of an orthodontic appliance furnished, in whole or in part, under this Dental Plan. d. X-rays and extraction procedures incident to orthodontics are not covered by orthodontic benefits but may be covered under other provisions of the program subject to all the terms and provisions of the program. e. Surgical procedures for correction of malalignment of teeth and/or jaws are not covered. f. The Dental Plan will not pay for services for crowns and cast restorations and prosthodontics in lieu of orthodontic treatment.
PROSTHODONTIC BENEFITS	Prosthodontic benefits are limited as follows: a. Prosthodontic appliances including (but not limited to) fixed bridges and partial or complete denture will be covered only after five years have elapsed following any prior provision of such appliance under any Dental Plan provided by the Plan, unless there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement or a prosthodontic appliance not covered under a Dental Plan provided by the Plan will be covered only if the appliance is unsatisfactory and cannot be made satisfactory. b. Implants (artificial materials implanted into or on bone or soft tissue) or the surgical removal of implants are covered benefits under the Plan as follows: Delta Dental will allow the cost of a 3-unit bridge toward the cost of the surgical placement of the implant. The Plan will not cover any of the other costs associated with the implant (i.e. cost of the abutment or crown or bridge over the top of the implant). If the Dental Plan makes an allowance toward the cost of implants, The Plan will not pay for any replacement placed within five years thereafter. c. The Dental Plan will pay the applicable percentage for a standard cast chrome or acrylic partial denture or a standard complete denture, up to a maximum fee allowance determined by Delta for a standard denture. (A "standard" denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials). Maximum allowances are revised periodically as dental fees change. Any denture and/or related service for which a charge is made which exceeds this allowance is considered an optional service, and the patient is responsible for the portion of the fee in excess of the allowance.

10. DENTAL PLAN EXCLUSIONS

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

a. Services for injuries or conditions which are compensable under **Workers' Compensation** or Plan Sponsors' Liability Laws; services which are provided to the Covered Individual by any Federal or State Government Agency or are provided without cost to the Covered Individual by any municipality, county or other political subdivision except as such exclusion may be prohibited by law.

b. Services with respect to **congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons**, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), and fluorosis (a type of discoloration) of the teeth, except those services provided to newborn children for congenital defects or birth abnormalities or services that may be provided under Orthodontic Benefits.

c. Services for restoring tooth structure **lost from wear, for rebuilding or maintaining chewing surfaces** due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to: equilibration and periodontal splinting.

d. **Prosthodontic services** or any single procedure started prior to the date the person became eligible for such services under this Dental Plan.

e. **Prescribed drugs, pre-medication or analgesia**.

f. **Experimental** procedures.

g. Charges by any **hospital or other surgical or treatment facility** and any additional fees charged by the Dentists for treatment in any such facility.

h. Charges for **anesthesia,** other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.

i. **Extra oral grafts** (grafting of tissues from outside the mouth to oral tissues).

j. Services with respect to any **disturbance of the temporomandibular joint (jaw joint).**

k. Services performed by any **person other than a Dentist** (Doctor of Dentistry) or auxiliary personnel legally authorized to perform services under the direct supervision of a Dentist.

11. VISION PLAN

OVERVIEW OF THE VISION PLAN

Vision Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA.
A separate election or opt out is required for vision plan benefits and vision plan premiums are adjusted for individuals that opt in or out of coverage.

The Vision Plan is designed to provide for regular vision examinations and benefits toward eyeglasses or contact lenses.

There is no vision network so you are free to seek care from any vision provider. You pay for the service and later send your claims to the Claims Administrator for reimbursement.

Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; and this Plan will reimburse as noted in the Schedule of Vision Benefits. The itemized bill reflecting the provider's fees must be submitted to the Claims Administrator for reimbursement. You will be reimbursed according to the Allowed Charge up to the amount allowed by the Plan.

Covered expenses are noted in the Schedule of Vision Benefits in this chapter. You are covered for expenses you incur for many, but not all, routine vision services and supplies that are determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that:

- **Services or supplies are not excluded** from coverage (as provided in the Vision Exclusions chapter of this document); and
- **Services or supplies are not in excess** of a Maximum Plan Benefit as shown in this Vision chapter; and
- The charges for services are an **"Allowed Charge,"** as that term is defined in the Definitions chapter.

DEFINITION OF TERMS USED IN THIS VISION PLAN

- A **vision exam** includes a professional examination and an eye refraction including case history, exam for pathological abnormalities of the eyes and lids, ranges of clear single vision and balance and coordination of muscles for far-seeing and near-seeing and special working distances.
- **Dispensing optician** means a person qualified to manufacture and sell eyeglasses and/or contact lenses.
- **Optometrist** is a person licensed to practice optometry.
- **Ophthalmologist** is a physician licensed to practice ophthalmology.

12. SCHEDULE OF VISION BENEFITS

This chart shows what the Plan pays. You pay the difference between the amount that is payable by this Plan and the provider's bill.

Covered Vision Benefits	Explanations and Limitations *See also the Vision Plan Exclusions section.*	Vision Benefits Payable by the Plan
Vision Examination	• One vision exam is payable each calendar year.	• 100% after a $10 copay to a maximum of $75 payable by the Plan
Frames for Eyeglasses[1]	• One frame is payable each calendar year.	• 100% after a $10 copay to a maximum of $125.
Lenses for Eyeglasses[1]	• Lenses are payable each calendar year.	• **Single Vision Lenses:** 100% after a $10 copay to a maximum of $45 payable by the Plan. • **Bifocal Lenses:** 100% after a $10 copay to a maximum of $60 payable by the Plan. • **Trifocal Lenses:** 100% after a $10 copay to a maximum of $82.50 payable by the Plan. • **Lenticular Lenses**: 100% after a $10 copay to a maximum of $120 payable by the Plan.
Contact Lenses[1]	• One set of contact lenses are payable each calendar year.	• 100% after a $10 copay to a maximum of $300 payable by the Plan.

[1] The maximum benefit payable for vision hardware (including frames, lenses and/or contact lenses) is $300 per person per calendar year.

FILING A VISION CLAIM/APPEALING A DENIED CLAIM

If you use the services of a vision provider, you will need to pay the provider for all services and then, at a later date but within one year of the date of service, submit the bill to the Claims Administrator (whose name and address are listed on the Quick Reference Chart in the front of this section of the handbook).

You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits. Vision claims submitted beyond 12 months of the date of service may not be considered for reimbursement. Your appeal of a denied vision claim should be submitted to the Plan according to the Claim Appeal procedures in the Claim Filing and Appeals Information chapter of this document.

13. VISION PLAN EXCLUSIONS

The Vision Plan is designed to cover visual needs rather than cosmetic materials. In addition to the General Exclusion and Limitations in the Medical Plan Exclusions chapter, the following is a list of services and supplies or expenses **not covered (excluded) by the Vision Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Vision Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

1. Vision services and supplies that cost more than the Plan's allowance as noted in the Schedule of Vision Benefits.
2. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
3. Glasses secured when there is no prescription charge, such as reading glasses obtained from a drugstore.
4. Experimental and/or investigational treatment or procedure.
5. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Keratoplasty (ALK), or Laser In Situ Keratomileusis (LASIK).
6. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies.
7. Vision therapy (orthoptics) and supplies.
8. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.
9. Expenses related to the treatment of contact lens intolerance.

14. CLAIM FILING AND APPEALS INFORMATION

This chapter describes the procedures for filing claims for certain benefits under this Fund and for appealing adverse benefit determinations in connection with those claims in compliance with 29 CFR §2560.503-1. Claims covered by these procedures include those claims filed under the Medical Plans (including prescription drug claims), the Dental Plan and the Vision Plan. For claims procedures under Life and AD&D Insurance refer to that chapter of this document for details.

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

This chapter also discusses the process the Fund undertakes on **certain appealed claims, to consult with a health care professional** with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is experimental or investigational).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A Qualified Medical Child Support Order (QMCSO) may require the Trust to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received an QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information regarding QMCSOs, see the Eligibility chapter of this document.

WHEN YOU MUST REPAY PLAN BENEFITS

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

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

then, the Fund will be entitled to:

a. A refund from you or your Health Care Provider for the difference between the amount paid by the Fund for those expenses and the amount of benefits that should have been paid by the Fund for those expenses based on the actual facts;
b. Offset future benefits if necessary in order to recover such expenses; and/or
c. Its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

Time Limit For Initial Filing of Health Claims

All post-service claims must be submitted to the Fund within **ONE YEAR** from the date of service.
No Fund benefits will be paid for any claim not submitted within this period.

ADDITIONAL INFORMATION NEEDED

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

COORDINATION OF BENEFITS (COB) Provision

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a person is covered so that the total benefits available will not exceed one hundred percent of allowable expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your

eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits chapter for more information.

WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable without a financial penalty only if the Fund 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 chapter. You are not required to obtain approval in advance for emergency care including care provided in a hospital emergency room or hospital admission for delivery of a baby.

KEY DEFINITIONS

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

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

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

Appropriate Claims Administrator	Types Of Claims Processed
Medical Claims Administrator	• Medical, behavioral health and Vision plan post-service claims.
Utilization Management Program	• Preservice, urgent or concurrent non-behavioral health claims.
Behavioral Health Program	• Preservice, urgent or concurrent behavioral health claims.
EAP Program	• Preservice claims for EAP visits.
Prescription Drug Program	• Pre-service, urgent and post-service claims for out-of-network retail drugs.
Dental Plan	• Dental post-service claims.
Life Insurance Company	• Life and AD&D Claims. See the Life Insurance chapter for complete details.

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 chapter) in accordance with the Plan's claims procedures, described in this chapter.

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

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

- **Be written or electronically** submitted (oral communication is acceptable only for urgent care claims),
- **Be received by the Appropriate Claims Administrator** (as that term is defined in this chapter);
- **Name a specific individual**,
- **Name a specific medical condition or symptom**,
- **Name a specific treatment, service or product** for which approval or payment is requested, and
- **Made in accordance with the Plan's benefit claims filing procedures** described in this chapter.

A claim is NOT:

- A request made by **someone other than** the individual or his/her authorized representative;
- A request made by a **person who will not identify him/herself** (anonymous);
- 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;
- A request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
- 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;
- A **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim; and
- 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.

Concurrent Care Claim: A concurrent care claim refers to a Fund 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.

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

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

Independent Review Organization or IRO: means an entity that conducts independent external reviews of adverse benefit determinations in accordance with the Plan's external review provisions and current federal external review regulations.

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.

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

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

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required 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 (see also the section on "When The Fund Can End Your Coverage For Cause" described in the Eligibility chapter).

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

Urgent Care Claim: An urgent care claim is a claim (request) 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.

AUTHORIZED REPRESENTATIVE

This Fund recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a

network health care professional. Under this Plan you do not need to designate in writing that the network Health Care Professional is your authorized representative if that network Health Care Professional is part of the claim appeal.

The Fund requires a written statement from an individual that he/she has designated an authorized representative (except for a health care professional) 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.

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

Once the Fund receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Fund 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 Fund's written authorized representative form.

The Fund 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.

REVIEW OF ISSUES THAT ARE NOT A CLAIM AS DEFINED IN THIS CHAPTER

A Plan Participant may request review of an issue (that is not a claim as defined in this chapter) by writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. The request will be reviewed and the participant will be advised of the decision.

COMPLYING WITH MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

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

TO FILE A POST-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

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

1. Plan benefits for post-service claims are considered for payment on the receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim, but sometimes additional information or records may be required.
2. 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.
3. If health care services are provided through the Preferred Provider Organization (PPO), the PPO Health Care Provider will usually submit the written proof of claim directly to the Appropriate Claims Administrator.
4. If you pay for non-PPO health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered Dependent paid some or all of those charges. Plan benefits will be paid to you up to the amount allowed by the Fund for those eligible expenses. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.
5. **Claim Forms:** Occasionally a health care provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this chapter) to find out if they require you to complete a claim form. If a claim form is required it may be obtained from the Appropriate Claims Administrator whose name and address are listed on the Quick Reference Chart in the front of this document.
   - Complete the Employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."

- The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician, Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
  - A description of the services or supplies provided.
  - Details of the charges for those services or supplies including CPT/CDT codes.
  - Diagnosis including ICD codes.
  - Date(s) the services or supplies were provided.
  - Patient's name, (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.
- 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 Fund.
- Complete a **separate claim form** for each person for whom Plan benefits are being requested.
- 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.
- Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.

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

7. The Appropriate Claims Administrator will review your post-service claim not later than 30 calendar days from the date it receives the claim. You will be notified if you did not properly follow the post-service claims process.
   - This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30-day period using a written Notice of Extension.
   - 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.
   - 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.
   - **Proof of Dependent Status:** (see also the Proof of Dependent Status subheading in the Eligibility chapter of this document)
     - When processing claims submitted on behalf of a newborn Dependent Child the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (e.g., copy of certified birth certificate for newborn).
     - When processing claims submitted on behalf of a Dependent Child who is age 26 or older, the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g., disability status verification).
     - If claims are submitted on behalf of a **Dependent for whom the Plan has not yet received proof of dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Plan Administrator of the child's eligibility for coverage, before the claim can be considered for payment.
     - When processing claims submitted on behalf of a new Spouse, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g., copy of marriage certificate).
   - When processing **claims related to an accident** the Appropriate Claims Administrator may need information about the details of the accident in order to consider the claim for payment.
   - You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
   - The Appropriate Claims Administrator will then make a claim determination not later than 15 calendar days from the earlier of the date the Fund receives the additional information or the date displayed in the Notice of Extension on which the Fund will make a decision if no additional information is received.

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

9. **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.

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

11. If you do not understand English and have questions about a claim denial, contact the Administrative Office or the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-617-2478.
    - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.
    - CHINESE (**中文**)**如果需要中文的帮助**，请拨打这个号码1-855-617-2478.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.

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

APPEAL OF A DENIAL OF A POST-SERVICE CLAIM

1. The Fund maintains a **one level** appeals process. Appeals for all claims, except Dental Plan claims, must be in writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. Dental Plan claim appeals should be directed to the Dental Plan (whose address is on the Quick Reference Chart). You will be provided with:
    - The opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
    - The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
    - A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
    - Automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the 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 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.

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:
  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - Provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

2. There is **no extension permitted** in the appeal review process.
3. A determination will be made on your appeal request according to the following timeframes:
   - **If an appeal is filed with the Dental Plan**, the review will occur within 60 days.
   - **For an appeal filed with the Board of Trustees <u>more than 30 days</u> before the next Board meeting**, the review will occur at the next Board meeting date. **If an appeal is filed with the Board of Trustees <u>within 30 days</u> of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.
     - If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Fund will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
     - After the decision on the appeal, you will be notified of the benefit determination on the appeal no later than five calendar days after the benefit determination is made.
4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Fund's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.
5. If the claim was denied due to a medical judgment (medical necessity, experimental or investigational) the Fund will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

6. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - Information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - The statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review;
   - The specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - Reference the specific Plan provision(s) on which the determination is based;
   - A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - An explanation of the Plan's 2nd level appeal (if any) and the external review process (when external review is relevant), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
   - If the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
   - If the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

- The statement that "You and the Fund may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

7. If you do not understand English and have questions about a claim denial, contact the Administrative Office or the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-617-2478.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.
   - CHINESE (**中文**)：**如果需要中文的帮助**，请拨打这个号码1-855-617-2478.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.
8. This concludes the post-service appeal process under the Fund. The Fund does not offer a voluntary post-service appeal process except for post-service claim appeals that were managed by the Dental Plan. See below for the Voluntary appeals process for dental appeals.
9. **Voluntary Appeals Process for Dental Post-Service Claims:** If you are still dissatisfied with the appeal as performed by the Dental Plan, within 180 days of the denial on the dental appeal, you may submit your voluntary appeal to the Board of Trustees as follows:
   - If an appeal is filed with the Board of Trustees more than 30 days before the next Board meeting, the review will occur at the next Board meeting date.
   - If an appeal is filed with the Board of Trustees within 30 days of the next Board meeting, the Board review will occur no later than the second meeting following receipt of the appeal.
   - If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Fund will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
   - After the decision on the appeal, you will be notified of the benefit determination on the voluntary appeal no later than five calendar days after the benefit determination is made. This concludes the voluntary appeal process under the Fund.

HOW TO FILE AN URGENT CARE CLAIM FOR BENEFITS UNDER THIS PLAN

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

1. Urgent care claims (as defined previously in this chapter) may be requested by you orally or by writing to the Appropriate Claims Administrator whose phone number and mailing address are listed on the Quick Reference Chart in the front of this document.
2. 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 the Fund to be the authorized representative bypassing the need for completion of the Fund's written authorized representative form.
3. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, 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 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.
4. You will be notified of the Fund's benefit determination as soon as possible but **not later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.
5. **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 Fund's benefit determination on the urgent care claim as soon as possible but not later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

6. **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.

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

8. If you do not understand English and have questions about a claim denial, contact the Administrative Office or the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-617-2478.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.
   - CHINESE (**中文**）**如果需要中文的帮助**，请拨打这个号码1-855-617-2478.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.

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

APPEAL OF A DENIAL OF AN URGENT CARE CLAIM

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

2. You will be provided with:
   - The opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - Automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the 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 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.

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Fund 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 Fund will:
  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - Provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

3. A determination will be made on the appeal (without the opportunity for an extension) as soon as possible but not later than 72 hours after receipt of the appeal.

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

5. If you do not understand English and have questions about a claim denial, contact the Administrative Office or the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-617-2478.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.
   - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码1-855-617-2478.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.

6. This concludes the urgent care claim appeal process under this Plan. This Plan does not offer a voluntary urgent care appeal process.

HOW TO FILE A CONCURRENT CLAIM FOR BENEFITS UNDER THIS PLAN

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

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.
2. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, 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 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.
3. 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 chapter.
4. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Preservice or Post-service claim sections of this chapter.
5. **If the concurrent 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.
6. **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
   - Identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - State that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   - Give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
   - Reference the specific Plan provision(s) on which the determination is based;
   - Contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - Provide an explanation of the Fund's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
   - Contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
   - If the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
   - If the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
7. If you do not understand English and have questions about a claim denial, contact the Administrative Office or the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-617-2478.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.
   - CHINESE (中文）如果需要中文的帮助，请拨打这个号码1-855-617-2478.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.

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

APPEAL OF A DENIAL OF A CONCURRENT CARE CLAIM

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, at their phone number or address listed on the Quick Reference Chart in the front of this document.
2. You will be provided with:
   - The opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - Automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the 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 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.
   - A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary will:
     - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefit is reduced or treatment is terminated.
4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - Information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - The statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   - The specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - Reference the specific Plan provision(s) on which the determination is based;
   - A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - An explanation of the Plan's 2nd level appeal (if any) and the external review process (when external review is relevant), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

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

5. If you do not understand English and have questions about a claim denial, contact the Administrative Office or the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-617-2478.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.
   - CHINESE (**中文**)**如果需要中文的帮助**，请拨打这个号码1-855-617-2478.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.
6. This concludes the concurrent claim appeal process under this Plan. This Plan does not offer a voluntary concurrent appeal process.

HOW TO FILE A PRE-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

1. A claim for pre-service (as defined in this chapter) must be made by a claimant or the claimant's authorized representative (as described in this chapter) in accordance with the Fund's claims procedures outlined in this chapter.
2. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Utilization Management chapter of this document) to the Appropriate Claims Administrator (as defined in this chapter).
3. 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.
4. If you did not follow the pre-service claim filing process, you will be notified as soon as possible or within five calendar days from your request.
5. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period using a written Notice of Extension.

6. 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.
7. 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.
8. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
9. A claim determination will be made not later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will make if no additional information is received.
10. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, 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 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.

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

12. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
    - Identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
    - State that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
    - Give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
    - Reference the specific Plan provision(s) on which the determination is based;
    - Contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
    - Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    - Provide an explanation of the Fund's appeal procedure along with time limits;
    - Contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
    - If the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
    - If the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
    - Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

13. If you do not understand English and have questions about a claim denial, contact the Administrative Office or the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-617-2478.
    - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.
    - CHINESE (**中文**）**如果需要中文的帮助**，请拨打这个号码1-855-617-2478.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.

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

APPEAL OF A DENIAL OF A PRE-SERVICE CLAIM

1. Appeals must be in writing to the Appropriate Claims Administrator whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:

    - The opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
    - The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
    - A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
    - automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the 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 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;

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary will:
  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

2. The Appropriate Claims Administrator will make the determination on the pre-service appeal not later than 15 calendar days from receipt of the appeal.
3. There is **no extension permitted** to the Fund in the appeal review process. You will be sent a written notice of the appeal determination as discussed below.
4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
5. If the claim was denied due to a medical judgment (medical necessity, experimental or investigational) the Fund will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
6. You will receive a notice of the appeal determination. If that determination is adverse, it will include the following:
   - Information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - The statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   - The specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - Reference the specific Plan provision(s) on which the determination is based;
   - A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
   - A statement that you have the right to bring civil action under ERISA section 502(a) following the appeal;
   - An explanation of the Plan's 2nd level appeal (if any) and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
   - If the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
   - If the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
   - The statement that "You and the Fund may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
   - Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

7. If you do not understand English and have questions about a claim denial, contact the Administrative Office or the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-617-2478.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.
   - CHINESE (中文）如果需要中文的帮助，请拨打这个号码1-855-617-2478.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.
8. If still dissatisfied with the initial appeal determination on your pre-service claim you may, within 180 days of the appeal denial, file a request for a voluntary appeal as follows:
   - If an appeal is filed with the Board of Trustees more than 30 days before the next Board meeting, the review will occur at the next Board meeting date.
   - If an appeal is filed with the Board of Trustees within 30 days of the next Board meeting, the Board review will occur no later than the second meeting following receipt of the appeal.
   - If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Fund will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
   - After the decision on the appeal, you will be notified of the benefit determination on the voluntary appeal no later than five calendar days after the benefit determination is made. This concludes the voluntary appeal process under this Plan.

OUTLINE OF THE TIMEFRAMES FOR THE CLAIM FILING AND CLAIM APPEAL PROCESS

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

OVERVIEW OF CLAIMS AND APPEALS TIMEFRAMES

	Urgent	Concurrent	Pre-service	Post-service
Fund 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
Extension permitted during initial benefit determination?	No[1]	No	15 days	15 days
Appeal Review must be submitted to the Fund within:	180 days	180 days	180 days	180 days
Fund 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 Board timeframes noted in the chart on the next page.
Extension permitted during appeal review?	No	No	No	No

[1] No formal extension for urgent care claims, but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

POST-SERVICE APPEAL TIMEFRAMES FOR MULTIEMPLOYER PLAN WITH COMMITTEE OR BOARDS OF TRUSTEES THAT MEET AT LEAST QUARTERLY		
Appeal filed **within 30 days** of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal.	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Appeal filed **more than 30 days** before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.
Board's decision on the appeal to be provided to claimant as soon as possible after the Board decision but not later than five days after the Board's decision date.		

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"), if your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within the following parameters:

- 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 life/death benefits, AD&D benefits, dental plan and vision plan benefits.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

1. **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 (4) months of the date that you receive notice** of an Initial Claim Benefit Determination or adverse Appeal Claim Benefit Determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

   Because the Plan's internal review and appeals process, generally, must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

   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 medical plan claim not involving retail or mail order prescription drug expenses or behavioral health expenses;
   - The Prescription Drug Program provider, 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;
   - The Behavioral Health Program provider, with respect to a denied claim involving behavioral health expenses;

   Contact information for the Medical Plan Claims Administrator, the Prescription Drug Program provider, the Behavioral Health Program provider, and the Utilization Management Program provider is identified in the Quick Reference Chart, as amended from time to time.

A. **Preliminary Review of Standard Claims**.

1. Within five (5) business days of the Plan's or appropriate Plan designee's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:

   a. 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;

   b. 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;

   c. 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

   d. You have provided all of the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

   a. If your request is complete and eligible for external review; or

   b. 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)).

   c. If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. **Review of Standard Claims by an Independent Review Organization (IRO)**.

1. If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

   a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

   b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

   c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

   d. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

   In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

e. 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.

1.) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

2.) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

f. The assigned IRO's decision notice will contain:

1.) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

2.) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

3.) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

4.) 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;

5.) 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);

6.) A statement that judicial review may be available to you; and

7.) 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.

2. **External Review of Expedited Urgent Care Claims**.

A. You may request an expedited external review if:

1.) you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2.) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

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 Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;
- The Behavioral Health Program provider, with respect to a denied claim about an Urgent, Pre-service or Concurrent review determination involving behavioral health expenses.

Contact information for the Utilization Management Program provider, the Prescription Drug Program provider, and the Behavioral Health Program provider, is identified in the Quick Reference Chart, as amended from time to time.

B. **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).

C. **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 (such as via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

1.) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

2.) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

3. **Overview of the Timeframes During the Federal External Review Process**.

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan or appropriate Plan designee performs preliminary review	Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request	Immediately
Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review	Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review	Immediately
When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan or appropriate Plan designee assigns case to IRO	In a timely manner	Expeditiously
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously

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

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 review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.

No lawsuit may be started more than three years after the end of the year in which health care services were provided.

14

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Fund, the Board of Trustees, and other fiduciaries and individuals to whom responsibility for the administration of the Fund has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

FACILITY OF PAYMENT

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Fund 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 Fund's obligations to the extent of that payment. Neither the Fund, Board of Trustees, Appropriate Claims Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

15. COORDINATION OF BENEFITS (COB)

HOW DUPLICATE COVERAGE OCCURS

This chapter describes the circumstances when you or your covered Dependents may be entitled to medical and/or dental benefits under this Plan and may also be entitled to recover all or part of your medical and/or dental expenses from some other source. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

1. Another group health care plan; or
2. Medicare; or
3. Other government program, such as Medicaid, Tricare, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency.

This chapter describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party. Duplicate recovery of medical and/or dental expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits chapter, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Covered Individual or that provides medical or dental services to the Covered Individual. A "group plan" provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage.
2. Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with your family, **you must let this Plan (or its insurer) know about <u>all</u> your coverages when you submit a claim.**
3. Note that if a Participant has dual coverage under this plan the total amount of benefits payable under the Plan shall in no event exceed the amount of expense actually incurred for which benefits are payable under this Plan.
4. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental expenses incurred.** Sometimes the combined benefits that are paid will be less than the total expenses.

IMPORTANT INFORMATION ABOUT COORDINATION OF BENEFITS

Plan participants who are covered by more than one medical, dental or vision plan (called duplicate coverage) must let this Plan's Claims Administrators know about <u>all</u> the additional medical, dental and vision coverages they have.

Duplicate coverage includes, but is not limited to, another group plan, Medicare, Medicaid, Indian Health Services, motor vehicle insurance, or third party liability insurance.

COB INQUIRY: During the year (generally annually) you will be sent a letter asking about possible other (duplicate) coverage you or your dependents may have. You are encouraged to respond promptly to that request for information. If you do not respond to this COB inquiry letter and the Plan's COB information is more than 12 months old, your claims submitted to the Plan will be denied until you have provided that information.

Please contact the Claims Administrators listed on the Quick Reference Chart in the front of this document to report any duplicate coverage.

WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES

The Overriding Rules

An individual plan (that is, a non-group plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, group practice, individual practice plan or through the Health Insurance Marketplace, pays first; and this Plan pays second.

A. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

B. When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent/Dependent

A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if:
   1. The parents are married;
   2. The parents are not separated (whether or not they ever have been married); or
   3. A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

B. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
   1. The plan of the custodial parent pays first; and
   2. The plan of the spouse of the custodial parent pays second; and
   3. The plan of the non-custodial parent pays third; and
   4. The plan of the spouse of the non-custodial parent pays last.

F. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parents coverage and the dependent's spouse's coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the dependent.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an Active Employee (that is, an Employee who is neither laid-off nor retired), or as that Active Employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or Retired Employee's dependent, pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:
   1. In the amount or scope of a plan's benefits;
   2. In the entity that pays, provides or administers the plan; or
   3. From one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY:

When this Plan pays second, it will pay, with respect to each claim submitted for payment, up to 100% of **"Allowable Expenses" less** whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.
- If the coordinating plans determine benefits based on Allowed Charge, any amount in excess of the highest Allowed Charge is not an allowable expense.
- If the coordinating plans provide benefits or services based on negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines benefits based on Allowed Charge and the other coordinating plan provides Benefits or services based on negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

ADMINISTRATION OF COB

1. To administer COB, the Plan reserves the right to:
   - Exchange information with other plans involved in paying claims;
   - Require that you or your Health Care Provider furnish any necessary information;
   - Reimburse any plan that made payments this Plan should have made; or
   - Recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.
2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
4. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.
5. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's Allowed Charge amount.
6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
7. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

COB FOR RETAIL AND MAIL ORDER PRESCRIPTION DRUGS

If a Spouse (with other coverage that is primary) purchases eligible prescription drugs and wishes to coordinate with the benefits of this Plan, the Spouse will need to send the receipt of the prescription drug along with the EOB from the primary payer to the Claims Administrator of this Plan for consideration of coordination of benefits. Payment of prescription drug expenses will be subject to this Medical Plan's deductible and applicable coinsurance.

COORDINATION WITH MEDICARE

A. **Entitlement to Medicare Coverage:** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (generally, after a waiting period).

B. **Medicare Beneficiary May Retain or Cancel Coverage Under This Plan:** If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability, or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible employee remains actively employed, that employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage. In that case, this Plan pays first and Medicare pays second.

   If an eligible individual under this Plan is covered by Medicare and an employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage if there has been a COBRA Qualifying Event. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of the eligible employee's Dependents are covered by Medicare and the employee **cancels** that Dependent's coverage under this Plan (when voluntary cancellation is permitted), that Dependent will **not** be entitled to COBRA Continuation Coverage, since voluntary cancellation of coverage is not a COBRA Qualifying Event. The choice of retaining or canceling coverage under this Plan of a Medicare beneficiary is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

C. **Coverage Under Medicare and This Plan When You Are Totally Disabled:** If you (the employee) become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second. Under this Plan, Medicare will pay first and this Plan will pay second for a Medicare eligible Spouse/Dependent of an employee who is Totally Disabled.

D. **Coverage Under Medicare and This Plan When You Have End-Stage Renal Disease:** 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.

E. **How Much This Plan Pays When It Is Secondary to Medicare**

1. **When the Plan Participant Is Covered by this Plan and also by Medicare Parts A and/or B:** When the Plan Participant is covered by Medicare Parts A and/or B and this Plan, this Plan is secondary to Medicare. This Plan pays the same benefits provided for Active Employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Allowed Charge of the Health Care Provider.
2. **When the Plan Participant Is Covered by this Plan and also covered by Medicare Advantage (formerly called Medicare + Choice or Part C):** This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If a Plan Participant is covered by a Medicare Advantage Plan and also by this Plan, and obtains medical services or supplies in compliance with the rules of that Medicare program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for Active Employees less any amounts paid by the Medicare Advantage program.

   However, if the Plan Participant does not comply with the rules of the Medicare Advantage program, including without limitation, approved referral, preauthorization or case management requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the Plan Participant receives.
3. **When the Plan Participant Is Eligible For but Not Covered by Medicare**: If the Plan Participant is eligible for, but is not enrolled in, Medicare, this Plan pays the same benefits provided for Active Employees less the amounts that would have been paid by Medicare had the Plan Participant been covered by Medicare Parts A, B and D and not on the Allowed Charge of the Health Care Provider.
4. **When the Plan Participant is covered by this Plan and also Enters Into a Medicare Private Contract**: Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.
5. **When a Person is covered by this Plan and also covered by Medicare Part D (Prescription Drug Coverage):** 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/Non-Participating Employee and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary. For more information on Medicare Part D refer to www.medicare.gov or contact the Administrative Office.

COORDINATION WITH OTHER GOVERNMENT PROGRAMS

A. **Medicaid:** If a Covered Individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

B. **Tricare:** If a Covered Dependent is covered by both this Plan and the Tricare, the program that provides health care services to dependents of active armed services personnel, this Plan pays first and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary and this plan is secondary.

C. **Veterans Affairs Facility Services:** If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a Covered Individual 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 Charge.

D. **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.

E. **Motor Vehicle Coverage Required by Law:** If a Covered Individual is covered for medical and/or dental benefits by both this Plan and any motor vehicle coverage that is required by law, including but not limited to no-fault, uninsured motorist or underinsured motorist, the motor vehicle coverage pays first, and this Plan pays second, whether or not the motor vehicle is

insured. The Claims Administrator will request a signed Agreement, but will not withhold payment for claims that do not exceed (in total) $2,500.

F. **Other Coverage Provided by State or Federal Law:** If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

WORKERS' COMPENSATION

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the Employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your covered Dependent must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee.

THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise. (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions chapter), 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 Individual, his or her parents and/or a representative, guardian, conservator, or trustee of the Covered Individual, parent(s) or Dependent(s), hereinafter collectively called "Claimant" 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 or otherwise 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 Claimant whole pursuant to federal or state law or otherwise (sometimes referred to as the "make-whole" rule); and
   a) Without any reduction for legal or other expenses incurred by the Claimant in connection with the recovery against the third party or that third party's insurer pursuant to federal or state law or otherwise (sometimes referred to as the "common fund" rule) unless the Plan Administrator, in its sole discretion, agrees in writing to discount the Fund's Advance by an agreed-upon amount of such fees or expenses. The Fund disavows any claims a Covered Individual or other Claimant may make under any federal or state common-law defense, including, but not limited to, the make-whole rule or doctrine and/or the common-fund rule or doctrine; and
   b) Regardless of the existence of any federal or 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);
   c) Even if the recovery was reduced due to the negligence of the Claimant (sometimes referred to as "contributory negligence") or any other common law defense.

B. Reimbursement and/or Subrogation Agreement

The Claimant 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 Fund. If the ill or injured Claimant(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 Fund's rights**.

The Claims Administrator will request a signed Agreement, but will not withhold payment for claims that do not exceed (in total) $2,500.

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 Individual agrees:

1. To reimburse the Fund for all amounts paid or payable to the Covered Individual or that third party's insurer for the entire amount Advanced; and
2. That the Fund has the first right of reimbursement from any judgment or settlement including priority over any claim for non-medical charges, attorneys' fees or other costs and expenses;
3. To do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Fund's reimbursement and/or subrogation rights; and
4. To not assign the right of recovery to any third party without the specific consent of the Plan Administrator or designee;
5. To inform the Plan in writing if a covered Employee and/or covered Dependent(s) were injured by a third party and, within seven (7) days of such injury, provide information to the Plan Administrator;
6. To notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
7. To inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. Subrogation

1. By accepting an Advance, the Covered Individual agrees that the Fund will be subrogated to the Covered Individual'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 Fund 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 Fund may be substituted in place of the Covered Individual(s), but only to the extent of the amount of the Advance. The Fund is subrogated in any and all actions against third parties for the portion of all recoveries that the Fund is entitled.
2. Under its subrogation rights, the Fund may, at its discretion:
    a. 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 Individual, but in doing so, the Fund will **not** represent, or provide legal representation for the Covered Individual with respect to their damages that exceed any Advance; or
    b. Intervene in any claim, legal action, or administrative proceeding started by the Covered Individual against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

E. Application to Any Fund

1. The Fund's right to reimbursement and subrogation shall apply to any fund, account or other asset created:
    a. Pursuant to the judgment of any court awarding damages against any third part in favor of the ill or injured Covered Individual payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
    b. As a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Covered Individual.

F. Lien and Segregation of Recovery

By accepting the Advance the Covered Individual agrees to the following:

1. The Fund will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the Covered Individual. The Fund'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, homeowners, commercial liability insurance, medical or health insurance or other policy. The Fund's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.
2. The Fund holds in a constructive trust that portion of the recovery that is the extent of the Advance. The Covered Individual, 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 Fund.

3. Should the Covered Individual or those acting on their behalf such as a parent, representative, guardian, conservator or trustee, fail to maintain this segregated account or comply with any of the Fund'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 Fund receives all amounts that must be reimbursed.

G. Remedies Available to the Fund

In addition to the remedies discussed above, if the Covered Individual does not reimburse the Fund as required by this provision, the Fund may, at its sole discretion:

1. Apply any future Fund benefits that may become payable on behalf of the Covered Individual to the amount not reimbursed; or
2. Obtain a judgment against the Covered Individual for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the Covered Individual.
3. institute legal action to obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed. In such event, the covered Employee and/or covered Dependent(s) shall be liable for the amount Advanced as well as all of the Plan's costs of collection, including reasonable attorney fees and costs.

The Plan has six (6) years to seek reimbursement for all or part of an Advance received by a covered Employee and/or covered Dependent(s) because of any injury caused by a third party, and for which a covered Employee and/or Dependent or their counsel was awarded or received a monetary settlement from such injury from a court judgment, arbitration award, settlement or any other arrangement. The six-year timeframe begins from the date the Plan discovers that a covered Employee, covered Dependent(s) or their legal counsel was awarded or received such monetary recovery.

16. COBRA: CONTINUATION OF MEDICAL, DENTAL, AND VISION COVERAGE

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage: In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA, this Fund offers its Employees and their covered Dependents (called "Qualified Beneficiaries" by the law) the opportunity to elect **a temporary continuation ("COBRA Continuation Coverage") of the group health coverage** sponsored by the Fund, including medical, dental and vision coverages, (the "Plan"), when those coverages would otherwise end because of certain events (called "Qualifying Events" by the law).

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

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.

IMPORTANT: This chapter serves as a notice to summarize your rights and obligations under the COBRA continuation coverage law. It is provided to all covered Employees, and their covered Spouses and is intended to inform them (and their covered Dependents, if any) in a summary fashion 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 notice carefully and be familiar with its contents.

Who is Entitled to COBRA Continuation Coverage; When (The Qualifying Event); and for How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. 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.

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

Who is entitled to COBRA Continuation Coverage (the Qualified Beneficiary), When (the Qualifying Event), and for how long is shown in the following chart:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	Not applicable	36 months	36 months
Employee becomes divorced or legally separated.	Not applicable	36 months	36 months
Dependent Child ceases to have Dependent status.	Not applicable	Not applicable	36 months

Failure To Elect COBRA Continuation Coverage

In considering whether to elect COBRA continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

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 chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the time the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months (a total of 29 months) under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons set forth in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Medicare Entitlement

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

Procedure On When The Plan Must Be Notified of a Qualifying Event (Very Important Information)

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

That notice should be sent to the COBRA Administrator whose address is listed on the Quick Reference Chart in the Introduction chapter of this document.

If such a notice is NOT received by the COBRA Administrator within the 60-day period, the Qualified Beneficiary will NOT be entitled to choose COBRA Continuation Coverage.

Other Fund officials or Employees should notify the COBRA Administrator of these events: an Employee's death, termination of employment or reduction in hours making the employee ineligible for coverage. However, **you or your family should also notify the COBRA Administrator promptly and 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 the Fund's transmittal of information to the COBRA Administrator.

Notice When You Become Entitled To COBRA Continuation Coverage

When your health care coverage ends because your employment terminates, your hours are reduced so that you are no longer entitled to coverage under the Fund, you die, or when the COBRA Administrator is notified that a Dependent Child lost Dependent status, you divorced or were legally separated, 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.

Failure to notify the Fund in a timely fashion may jeopardize an individual's right to COBRA coverage.

Under the law, you and/or your covered Dependents will then **have only 60 days from the date of receipt of that notice**, to enable you and/or them to apply for COBRA Continuation Coverage.

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

The COBRA Continuation Coverage That Will Be Provided

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

Paying for COBRA Continuation Coverage (The Cost of COBRA)

1. By law, any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated Employees and families (including both the Fund's and Employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Fund may charge a total of 150% of the full cost of coverage applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.
2. Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.
3. **You will not receive an invoice (bill)** for the initial COBRA premium payment or for the monthly COBRA premium payments. **You are responsible for making timely payments for COBRA continuation coverage** to the COBRA Administrator listed on the Quick Reference Chart.

Grace Periods

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

After the initial COBRA payment, **subsequent COBRA premium payments** are due on the first day of each month, but there will be a **30-day grace period** to make those subsequent payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked. For example, if the COBRA payment is due on July 1, the qualified beneficiary will have until July 30th to make the COBRA premium payment for July. Payment on or after July 31 is a late payment and COBRA coverage will be cancelled back to June 30th.

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 as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.

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

IMPORTANT REMINDERS

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

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

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

Addition of Newly Acquired Dependents

If, while you (the Employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or Dependent Child for coverage for the balance of the period of COBRA Continuation 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 Continuation Coverage. Contact the COBRA Administrator to add a Dependent.

Loss of Other Group Health Plan Coverage

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

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

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a qualifying event but the Plan 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 Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

A Spouse and Dependent Child who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend their COBRA from 18 or 29 months, to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled* to Medicare benefits (under Part A, Part B or both), or a Dependent Child ceasing to be eligible for coverage as a dependent under the group health plan.

*NOTE: Medicare entitlement is not a qualifying event under the Fund, and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and Dependents who are qualified beneficiaries.

NOTIFYING THE FUND: 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 Fund in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail or hand-delivered and is to include your name, the second qualifying event, the date of the second qualifying event, and appropriate documentation in support of the second qualifying event, such as divorce documents.

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

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

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

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

If, prior to the qualifying Event, or at any time during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child 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 Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:
    - The Social Security Administration (SSA) determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**
    - **Notifying the Fund:** you or another family member follow this procedure (to notify the Fund) 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 Fund in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail or hand-delivered and is to include your 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 Plan Administrator before the end of the 18-month COBRA Continuation period.
2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be higher than the cost for that coverage during the 18-month period.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

The Fund 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 Fund 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. Once COBRA coverage terminates early it cannot be reinstated.

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

1. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid in full and on time;
2. The date, after the date of the COBRA election, on which the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both);
3. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan (and that plan does not contain any legally applicable exclusion or limitation with respect to a pre-existing condition that the covered person may have. Such pre-existing condition exclusions will become prohibited beginning with the plan year in 2014). IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan.
4. During an extension of the maximum 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 covered person must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).
6. The date on which the Fund no longer provides group health coverage to any of its Employees.

No Entitlement to Convert to an Individual Health Plan after COBRA Ends: There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

Appealing an Adverse Determination Related to COBRA

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

a. Send a written request for an appeal to the COBRA Administrator within **60 days** of the date you received the adverse determination letter.
b. Explain why you disagree with the adverse determination.
c. Provide any additional information you want considered during the appeal process.
d. Include the most current name and address of each individual affected by the adverse determination.

The COBRA Administrator will respond in writing to this initial (Level 1) appeal request within 60 days of the Plan's receipt of the request for appeal. The appeal response will be sent to the address provided by the individual.

If still dissatisfied with the initial appeal determination on your adverse determination related to COBRA you may, within 60 days of the appeal denial, file a request for a voluntary second (Level 2) appeal as follows:

a. If a second level appeal is filed with the Board of Trustees more than 30 days before the next Board meeting, the review will occur at the next Board meeting date.
b. If a second level appeal is filed with the Board of Trustees within 30 days of the next Board meeting, the Board review will occur no later than the second meeting following receipt of the appeal.
c. If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the Level 2 appeal. If such an extension is necessary the Fund will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

After the decision on the Level 2 appeal, you will be notified of the benefit determination no later than five calendar days after the benefit determination is made.

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

Whom to Contact if You Have Questions or To Give Notice of Changes in Your Circumstances (Very Important Information):

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 Introduction chapter of this document.

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

1. Within 31 days if you have **changed marital status**; or have a new Dependent Child; or
2. Within 60 days of the date you or a covered Dependent Spouse or Child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. Within 60 days if a covered child **ceases to be a "Dependent Child"** as that term is defined by the Fund; or
4. Promptly if you or your Spouse have **changed your address or is no longer disabled**.

BRIEF OUTLINE ON HOW CERTAIN LAWS INTERACT WITH COBRA

FMLA and COBRA:

Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur **after** the FMLA period expires, **if** the person does not return to work and thus loses coverage under their group health plan. Then the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the Employee notifies the Employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

Leave of Absence (LOA) and COBRA:

If an Employee is offered alternative health care coverage while on LOA, and this alternate coverage is **not identical** in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a qualified beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required. If the alternative coverage is identical in cost and benefits but the coverage period is **less than** the COBRA maximum period (18, 29, 36 months), the lesser time period can be credited toward covering the 18-, 29-, or 36-month COBRA period. For example, if an Employee is allowed to maintain the same coverage and premium for six months while on an LOA, the six months can be credited toward the COBRA maximum period.

17. GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

NAME OF THE PLAN

IBEW/Western Utilities Health and Welfare Trust Fund

PLAN SPONSOR

IBEW/Western Utilities Health and Welfare Trust Fund. The Fund's address is in care of the Plan Administrator (noted on the Quick Reference Chart in the front of this document).

EMPLOYER IDENTIFICATION NUMBER (EIN)

Plan Sponsor: 87-0496328

PLAN NUMBER

Medical Plan, Vision Plan and Life Insurance Plan: 505

Dental Plan: 534

TYPE OF PLAN

Single Employer-sponsored Welfare Benefits Plan

TYPE OF ADMINISTRATION

The Fund is liable for all eligible health care expense benefits under the self-funded Medical, Dental and Vision Plan.

- The Claims Administrator (whose name and address is listed on the Quick Reference Chart in the Introduction chapter of this document) pays the non-HMO medical and vision claims, but does not insure or otherwise guarantee any of the benefits under the Plan.
- The Dental Claims Administrator (whose name and address is listed on the Quick Reference Chart in the Introduction chapter of this document) pays dental claims, but does not insure or otherwise guarantee any of the benefits under the Plan.
- The Prescription Drug Program (whose name and address is listed on the Quick Reference Chart in the Introduction chapter of this document) pays prescription drug claims obtained from in and out-of-network retail/mail order pharmacies, but does not insure or otherwise guarantee any of the benefits under the Plan.
- The Fund contracts with a stop-loss insurance company that will reimburse the Fund for certain losses in excess of amounts described in the stop-loss insurance policy. This policy does not insure or guarantee, and has no obligation to pay any Plan benefits or to make any other payments to any Plan Participant.
- The Life and AD&D Insurance benefits described in this document are fully insured with an insurance company whose name is listed on the Quick Reference Chart in the Introduction chapter of this document. This document provides an outline (summary) of the Life and AD&D Insurance benefits that have been provided to you in a Certificate of Coverage by the Insurance Company.

PLAN ADMINISTRATOR/PLAN SPONSOR

The Board of Trustees of the IBEW/Western Utilities Health and Welfare Trust Fund.

CLAIMS REVIEW FIDUCIARY (Claims Administrator)

Refer to the Quick Reference Chart in the front of this document for the names and addresses of the claims administrators for medical, vision, dental and prescription drugs.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator at the following address or Legal Counsel or on any Trustee of the Plan.

Plan Administrator	Legal Counsel
c/o BeneSys, Inc. P. O. Box 215 San Ramon, CA 94583 Toll-free Phone: 1-855-617-2478 Fax: 925-297-6655	Robert W. Hanula P.O. Box 279 Carbondale, CO 81623

See chart on next page for the address of each Trustee.

PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS

The Plan's requirements with respect to eligibility as well as circumstance that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility chapter in this document. The benefits provided by the Plan are described in the remaining chapters of this SPD/Plan Document such as in the Medical Expense Benefits, Schedule of Medical Benefits, Medical Exclusions, Dental Expense Benefits and Schedule of Dental Benefits, Dental Exclusions, and Vision Plan chapters.

COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to the International Brotherhood of Electrical Workers Local Unions No. 57 and 125 and PacifiCorp d.b.a. Pacific Power and Rocky Mountain Power collective bargaining agreements. A copy of such agreement(s) may be obtained upon written request to the Plan Administrator who may wish to make a reasonable charge for the copies, and is available for examination by Participants and beneficiaries at the office of the Claims Administrator (whose name and address are listed on the Quick Reference Chart in the Introduction chapter of this document).

CONTRIBUTION SOURCE

All contributions to the Fund are made by Employers in accordance with Collective Bargaining Agreements and Participation Agreements between the IBEW/Western Utilities Health and Welfare Trust Fund and Employers in the industry. The Collective Bargaining and Participation Agreements require contributions to the Fund. The Administrative Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of Covered Individuals working under the Collective Bargaining Agreement, additional information about the Collective Bargaining Agreement, and the Fund's investment of assets and checking accounts.

PLAN YEAR

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

MEDIUM FOR PROVIDING BENEFITS

Benefits under the Plan are provided from Trust assets which are accumulated under the provisions of the Collective Bargaining Agreement, Local Union 125 Participating Agreement effective August 1, 2005 and the Trust Agreement and held in Trust for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. Benefits are administered by claims administrators listed on the Quick Reference Chart in the front of this document.

PLAN AMENDMENTS OR TERMINATION OF PLAN

The Plan Administrator reserves the right to amend or terminate this Fund, or any part of it at any time. In order that the Fund may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Active Employees, the Plan Administrator may exercise its authority, at any time, and from time to time, but upon a non-discriminatory basis to:

1. Terminate or amend the amount or condition with respect to any benefit;
2. Alter or postpone the method of payment of any benefit;
3. Amend or rescind any other provisions of the Plan;
4. Change the providers for any portion of the Plan of benefits; or
5. Terminate the plan of benefits in its entirety or terminate portions of the plan of benefits.

Such amendment or termination shall be documented in amendment form to the Plan Document adopted and acted upon by the Board of Trustees.

PLAN TRUSTEES

Employer Trustees	Union Trustees
Julie Lewis, Chairperson PacifiCorp 825 NE Multnomah Street LCT 1800 Portland, OR 97232	Gary Cox IBEW Local Union No. 57 4551 South Atherton Drive Salt Lake City, UT 84123
Dana Ralston PacifiCorp 1407 West North Temple, Room 320-A Salt Lake City, UT 84116	Brent Donohue IBEW Local Union No. 57 4551 S. Atherton Drive Salt Lake City, UT 84123
David Lucas PacifiCorp 825 NE Multnomah Street LCT 1700 Portland, OR 97232	Marcy Grail (Secretary) IBEW Local Union No. 125 17200 Northeast Sacramento Portland, OR 97230
Curtis Mansfield PacifiCorp 825 NE Multnomah Street Suite 1700 Portland, OR 97232	Calvin Ockey IBEW Local Union No. 57 P. O. Box 934 Price, UT 84501

STATEMENT OF ERISA RIGHTS (Pertaining to the Health Plan Benefits)

As a Participant in the IBEW/Western Utilities 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 Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office (P. O. Box 215 San Ramon, CA 94583) and at other specified locations such as worksites and union halls, all documents governing the Fund, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Fund, 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.
3. Receive a summary of the Fund'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

1. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Fund as a result of a Qualifying Event, as described in the COBRA chapter. 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.
2. 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 (18 months for late enrollees) after your Enrollment Date in your coverage. The requirement on the Plan to provide a HIPAA certificate of creditable coverage will be eliminated effective December 31, 2014 because Health Reform prohibits medical plans from applying a pre-existing condition limitation starting with a plan year beginning on or after January 1, 2014.

Prudent Actions by Plan Fiduciaries

1. 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/Fund, called "fiduciaries" of the Plan/Fund, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

2. 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

1. 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.
2. 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.
3. 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.
4. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
5. If it should happen that Fund fiduciaries misuse the Fund'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

1. If you have any questions about your Fund, 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 the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration).

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Fund/Plan, the Plan Administrator, and other Fund fiduciaries and individuals to whom responsibility for the administration of the Fund/Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Fund benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Fund and Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Fund, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

NON-ASSIGNMENT

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person without the express written permission of the Plan Sponsor; 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.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations") as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). The following provisions address disclosures of PHI to the Plan's Board of Trustees (the "Trustees") for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

a. Disclosure of PHI to the trustees.

1. Disclosures by plan. The plan may disclose PHI to the trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

2. Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as payment or health care operations.

3. Disclosure by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

(i) The Plan's Payment activities;

(ii) Those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and

(iii) All of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

b. Uses and Disclosures of PHI by the Trustees. The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as payment or Health Care Operations or as otherwise permitted or required by the privacy regulations.

c. 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.

d. Privacy Safeguards. The trustees agree to:

1. Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

2. Ensure that any subcontractors or agents to whom the trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

4. Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

5. Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;

6. Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's Privacy Policies and Procedures;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's Privacy Policies and Procedures;

8. Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's Privacy Policies and Procedures;

9. Make internal practices, books and records relating to the use and disclosure of PHI available to the secretary of the U.S. Department of Health and Human Services for purposes of determining the plan's compliance with the Privacy Regulations;

10. If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the trustees agree to restrict and limit further uses and disclosures to the purposed that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained;

11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you; and

12. Ensure that adequate separation between the Plan and the Trustees is established, as described below.

e. **Adequate Separation**. The Trustees may use PHI only for Plan Administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan Administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

f. In compliance with **HIPAA Security regulations**, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in d above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

RIGHT OF THE FUND TO REQUIRE A PHYSICAL EXAMINATION

The Fund reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a physician, to be examined by a physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this provision. The cost of such an examination will be paid by the Fund.

APPEAL OF CLAIMS AND DISPUTES

To appeal a denied claim follow the processes outlined in the Claims Processing and Appeals chapter of this document.

AUTHORITY TO INTERPRET PLAN

The Board of Trustees, or where the Board of Trustees' responsibility has been delegated to others, such delegates shall have complete authority to determine the standard of proof required in any case and to apply and interpret this Plan. The decision of the Board of Trustees or its delegates will be final and binding.

All questions or controversies, of whatsoever character, arising in any manner or between any parties or person in connection with the Plan or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of this Plan, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Board of Trustees or, where the Board of Trustees responsibility has been delegated to others, to such delegates for decision. The decision of the Board of Trustees or its delegates shall be binding on all persons dealing with the Fund or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court having jurisdiction over such matters.

ALLOCATION AND DISPOSITION OF ASSETS UPON TERMINATION

In order for the Fund to carry out its obligation to provide benefits to all Participants within the limits of its resources, the Board of Trustees, to the extent permitted by law, has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these Plan Rules.

In addition, the Plan may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing (or other form of communication satisfying ERISA's communications requirements) of such notice to affected Participants. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid as set forth under the Termination of Trust Provisions below. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

TERMINATION OF TRUST PROVISIONS

The Trust Fund shall remain in full force and effect until terminated by the action of the Trustees. In the event of termination, the Trustees shall:

1. Make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and expenses incident to such termination.
2. Distribute the balance, if any, of the assets of the Trust Fund remaining in the hands of the Trustees in such manner as they determine will carry out the purpose of the Trust, including, but not limited to, the purchase of existing insurance benefits on a pro rata basis or the transfer of such funds to a successor trust having the same or similar purposes (including but not limited to, such purposes as health, welfare or pension) for the benefit of Participants.
3. Arrange for a final audit and report of their transactions and accounts for the purpose of terminating their Trusteeship.

4. In any event, upon termination, the Trustees may transfer group insurance policies and the balance, if any, of the assets of the Trust Fund remaining in the hands of the Trustees, or any portion thereof, to the Trustees of another Fund established for the purpose of providing substantially the same or similar group coverage or benefits (including but not limited to, such benefits as health, welfare or pension).

5. In no event shall any of the Fund, except for benefits due, revert to or be recoverable by any Participant, Employer or Union.

INFORMATION YOU MUST FURNISH TO THE FUND (Very Important Information)

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan. You must inform the Fund when you are divorced or when your Dependent child reaches age 26. You and your dependents if applicable will be held responsible for failure to provide such information.

If you fail to do so,

a. you or your covered Dependents may lose the right to obtain COBRA Continuation Coverage or

b. lose the right to continue coverage of a Dependent Child (such as a dependent child who has a physical or mental Disability); and/or

c. cause claims to not be considered for payment until eligibility issues have been resolved and reimbursement of the Plan has been made, and/or

d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and vision benefits

Submit such information in writing to the Claims Administrator at the address shown in the Quick Reference Chart in the Introduction chapter of this document. The information needed and timeframes for submitting such information are outlined below:

Type of Information Needed	Date Such Information is to be Submitted to the Plan
Change of name or address or the existence of other medical, dental or vision coverage for any Covered Individual	As soon as possible
Marriage, divorce, addition of a new Dependent, death of any Covered Individual	Preferably within 31 days but not later than 60 days
Employee receives a determination of disability from the Social Security Administration	Within 60 days after the later of the date of SSA determination or the Qualifying Event
Covered Dependent (Spouse or Child) becomes disabled or is no longer disabled	Within 31 days of the date the person becomes disabled or within 30 days if he or she loses their disability status
Covered child ceases to be a Dependent as defined by this Plan (e.g., over the limiting age of the Plan, etc.)	Preferably within 31 days but not later than 60 days of the date the child is no longer considered a Dependent
Medicare enrollment or disenrollment	Promptly

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA) AND NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NEWBORNS' ACT) & MENTAL HEALTH PARITY REGULATIONS

This Plan complies with the Women's Health and Cancer Rights Act, the Newborns' and Mothers' Health Protection Act and Mental Health Parity regulations. See the information described under Reconstructive services, Maternity services and Behavioral Health services in the Schedule of Medical Plan Benefits chart in this document.

HEADINGS, FONT AND STYLE DO NOT MODIFY PLAN PROVISIONS

The headings of chapters and subchapters (**APPEARING IN BOLD TEXT WITH SOLID CAPITAL LETTERS**) and of sections, paragraphs, and subparagraphs (**Appearing in Bold Text with Upper and Lower Case Letters**) are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

18. DEFINITIONS

The following are definitions of specific terms and words used in this Medical Plan document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions that pertain to claims are found in the Claim Filing and Appeals Information chapter of this document.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related.

Active Course of Orthodontia Treatment (Dental): The period beginning when the first orthodontic appliance is installed and ending when the last active appliance is removed.

Active Employee: means a person who by reason of his/her active employment meets the eligibility rules established by the IBEW/Western Utilities Health and Welfare Trust Fund. Eligibility rules are described in the Eligibility chapter of this document.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow. When benefits for acupuncture are payable such services must be ordered by a Physician. Services are covered only if the HealthCare Practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided.

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering a Plan Participant, except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense. Examples of expenses or services that are not Allowable Expenses appear in the chapter on Coordination of Benefits.

Allowed Charge/Allowed Amount (for the medical, dental and vision plans): Means the amount this Plan allows as payment for eligible medically necessary services or supplies. The allowed amount is determined by the Board of Trustees or its designee to be the lowest of:

1. **With respect to a network provider** (PPO or Participating network Health Care, Dental Care or Vision Care provider/facility), the fee set forth in the agreement between the PPO or Participating network Health Care, Dental Care or Vision Care Provider/facility and the PPO network or the Plan; or
2. **With respect to a non-network provider**, allowed amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers.

   The Plan's allowed amount list is not based on or intended to be reflective of fees that are or may be described as usual, reasonable, customary, and/or 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 chapter; or
3. For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; or
4. The Health Care, Dental Care or Vision Care Provider's/facility's actual billed charge.

In accordance with federal law, **with respect to Non-Network Emergency Room (ER) services**, the plan allowance for ER visit facility fees is to pay according to the billed charges, and the allowance for ER professional fees is the **greater** of:

- the negotiated amount for in-network providers (the median amount if more than 1 amount to in-network providers), or
- 100% of the plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
- (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

The Plan will not always pay benefits equal to or based on the Health Care, Dental Care or Vision Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "allowed amount" for health care services or supplies. Any amount in excess of the "allowed amount" does not count toward the Plan's annual Out-of-Pocket Maximums or Limits. Participants are responsible for amounts that exceed "allowed amounts" by this Plan. Reminder: 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.

Ambulance: A vehicle, helicopter, airplane or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

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

An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this chapter, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect. **Fixed Appliance:** A device that is cemented to the teeth or attached by adhesive materials. **Prosthetic Appliance:** A removable device that replaces a missing tooth or teeth.

Applied Behavior Analysis (ABA) Therapy: is the design, implementation, and evaluation of environmental modifications to attempt to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization. ABA Therapy is a technique that some use for individuals diagnosed with Autism Spectrum Disorder (that refers to disorders defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) manual as autistic disorder, asperger's syndrome or pervasive developmental disorder). Applied Behavior Analysis Therapy is payable when performed by a practitioner who is licensed or certified to perform Applied Behavioral Analysis Therapy in the state in which they are practicing.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are Medically Necessary.

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between this Plan's Allowed Amount 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 maximum 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 maximum and may result in balance billing to you. Typically, In-Network providers do not balance bill except in situations of third party liability claims**.** Out-of-Network Health Care Providers 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 In-Network providers.

Behavioral Health Disorder: A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Behavioral health disorder includes, among other things, autism, depression, schizophrenia, psychoses and is provided by Behavioral Health Practitioners as defined in this chapter.

Behavioral Health Practitioners: A psychiatrist, psychologist, or a mental health counselor or social worker who has a Master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment: Behavioral Health Treatment includes all inpatient services, including room and board, given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health for a Behavioral Health disorder (as defined in this chapter). If there are multiple diagnoses, only the treatment for the Illness that is identified under the Behavioral Health Disorder (as that term is defined in this chapter) is considered a Behavioral Health Treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders (as defined above) and which fully meets one of the following two tests:

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

A Behavioral Health Treatment Center that qualifies as a Hospital is covered by this Plan as a Hospital and not a Behavioral Health Treatment Center. A transitional facility, group home, halfway house or temporary shelter wilderness therapy program, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care is not a Behavioral Health Treatment Facility under this Plan.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Allowed Charge, after calculation of all Deductibles, Coinsurance and Copayments, and after determination of the Plan's exclusions, limitations and maximums.

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

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   - It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post partum care, and care of a child born at the center.
   - It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
   - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
   - It provides at least two beds or two birthing rooms.
   - It is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
   - It has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
   - It has trained personnel and necessary equipment to handle emergency situations.
   - It has immediate access to a blood bank or blood supplies.
   - It has the capacity to administer local anesthetic and to perform minor Surgery.
   - It maintains an adequate medical record for each patient which contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post partum summary.
   - It is expected to discharge or transfer patients within 48 hours following delivery.

A Birth (or Birthing) Center that is part of a Hospital, as defined in this chapter, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Bitewing X-Rays (Dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Board of Trustees: See the definition of Plan Sponsor.

Breastfeeding/Lactation Educator: is a provider who is currently certified as a lactation consultant by the International Board of Lactation Consultant Examiners (IBLCE). If not IBLCE certified, the provider must be a licensed, registered, or certified health care professional with referenced experience and training in lactation management. Breastfeeding/lactation educators help mothers initiate or maintain lactation and provide assessment, planning, intervention, and evaluation for optimal breastfeeding, working in conjunction with the mother's physician, midwife and/or baby's pediatrician.

Bridge, Bridgework (Dental):

- **Fixed**: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more Pontics and one or more retainers (Crowns or Inlays). The patient cannot remove the prosthesis.
- **Removable**: A prosthesis that replaces one or more teeth and which is held in place by clasps. The patient can remove the prosthesis.

Calendar Year: The 12-month period beginning January 1 and ending December 31. See also the definition of Plan Year. For the Medical plan, all annual medical Deductibles and Maximum Plan benefits are determined during the calendar year.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open heart surgery.

Case Management: A limited process, administered by the Utilization Management Company, in which its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the Fund to coordinate a timely and cost-effective treatment program while the patient is at a facility in order to determine the appropriate setting for care and treatment. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Certified Surgical Assistant: A person who does not hold a valid healthcare license as a RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon. Such individuals are not payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license.

Claims Administrator: The persons or companies retained by the Plan to administer the claim payment responsibilities and other administration or accounting services as specified by the Plan.

Coinsurance: That portion of Eligible Medical, Dental and Vision Expenses for which the covered person has financial responsibility. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered medical expenses in excess of the Plan's deductible. In some instances, the Covered Individual may be responsible for paying a higher percentage of those expenses, and in other instances, no Coinsurance applies.

Complications of Pregnancy: An added difficulty, complex state, disease or accident superimposed on a pregnancy without being specifically related, yet affecting or modifying the prognosis of the pregnancy, as determined by the Plan Administrator or its designee. Complications of pregnancy can include but are not limited to the following diagnoses: anemia, bleeding during pregnancy, cervical incompetence, ectopic or molar pregnancy, gestational diabetes, excessive vomiting, miscarriage, placenta abruptio or previa, preeclampsia, or preterm labor. Complications of pregnancy does not include common symptoms/discomforts associated with pregnancy such as spotting, false labor, morning sickness, skin changes, backache, headache, leg cramps, indigestion, constipation/hemorrhoids, or the usual lab/ultrasound tests to monitor status and progression of the pregnancy.

Compound Drugs: See the definition of Prescription Drugs.

Concurrent Review: A managed care program designed to assure that Hospitalization and Health Care Facility admissions and length of stay, Surgery and other health care services are Medically Necessary by having the Utilization Management (UM) Company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits chapter.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical, Dental or Vision Expense for certain services, generally those provided by network Health Care Practitioners, Hospitals (or emergency rooms of Hospitals), or Health Care Facilities.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

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

Course of Treatment (Dental): The planned program of one or more services or supplies, provided by one or more Dentists to treat a dental condition diagnosed by the attending Dentist as a result of an oral examination. The course of treatment begins when a Dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Individual: Any Employee (as that term is defined in this Plan), and that person's eligible Spouse or Dependent Child who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Covered Medical, Dental and/or Vision Expenses: See the definition of Eligible Medical, Dental and/or Vision Expenses.

Crown (Dental): The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Custodial Care: Care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or to perform the activities of daily living. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care may be payable by this plan under certain circumstances such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Deductible: The amount of Eligible Medical, Dental or Vision Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the Medical, Dental and Vision chapters of this document.

Dental: As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics. Dental includes outpatient prescription drugs prescribed by a dentist, physician or health care practitioner for a dental purpose such as fluoride tablets. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

Dental Care Provider: A Dentist, or Dental Hygienist or other Health Care Practitioner or Nurse as those terms are specifically defined in this chapter of the document, who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and acts within the scope of his or her license.

Dental Subspecialty Areas:

Subspecialty Area	Services related to the diagnosis, treatment or prevention of diseases related to:
Endodontics	The dental pulp and its surrounding tissues.
Implantology	Attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	Extractions and surgical procedures of the mouth.
Orthodontics	Abnormally positioned or aligned teeth.
Pedodontics	Treatment of dental problems of children.
Periodontics	Structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	Construction of artificial appliances for the mouth (Bridges, Dentures, Crowns).

Dental Hygienist: A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, and who acts within the scope of his or her license.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Denture: A device replacing missing teeth.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse as those terms are defined in this document. See also Eligible Dependent.

Dependent Child(ren):

A. For the purposes of this Plan, a Dependent Child is any of the Active Employee's children listed below who are under the age of 26, whether unmarried or married, including a:

- **Natural (biological) child**, (proof of relationship and age may be required),
- **Stepchild**, (proof of relationship and age may be required),
- **Legally adopted child, or child placed for adoption** with the Employee (proof of adoption or placement for adoption may be requested),
- **Foster child**, lawfully placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction (proof of relationship and age may be required);
- Child for whom the Employee has permanent **legal guardianship** under a court order (proof of guardianship may be requested) **and provided that the child qualifies as a dependent for federal income tax purposes.**
- A Dependent Child named as an "alternate recipient" in a **Qualified Medical Child Support Order (QMCSO)**. See the Eligibility and Definitions chapter for details on QMCSOs.

Disabled Adult Child: A dependent who is a disabled adult child may remain eligible under this Plan beyond the normal age limit if the Dependent child meets the eligibility requirements explained here:

- the child has reached his or her **26th birthday;** and
- the child is **unmarried;** and
- the child is incapable of self-sustaining employment by reason of **mental or physical disability** (as that term is defined in this Plan); and
- the child's disability existed before the attainment of this Plan's age limit.

This Plan may require initial and periodic **proof of disability**. The initial notification and proof of such incapacity must be submitted to PacifiCorp d.b.a. Rocky Mountain Power and Pacific Power and the Claims Administrator within 31 days of Initial Enrollment or if later, within 31 days of the date the Dependent Child's coverage would other wise end. A Dependent Child who is not covered under the Plan but becomes disabled after reaching the Fund's Dependent age limit is not eligible to enroll as a Dependent under the Fund.

No coverage will be extended for any individuals who do not satisfy the above requirements, including but not limited to these individuals: grandchild without a court ordered guardianship responsibility by the employee, the employee's son-in-law, or daughter-in-law.

B. See also the Proof of Dependent Status provisions in the Eligibility chapter.

C. **It is the Employee's obligation to inform the Fund promptly if any of the requirements set out in this definition of a Dependent Child are NOT met with respect to any child for whom coverage is sought or is being provided.**

D. **Coverage of a Dependent Child ends at the end of the month in which that child**:

1. Reaches his or her 26th birthday (and is not a disabled adult child as defined in this Plan); or
2. No longer meets the eligibility requirements of the Fund; or
3. Required contributions for coverage are not paid; or
4. For a child under a legal guardianship, the child no longer qualifies as a dependent for federal income tax purposes.

NOTE: As discussed in the Eligibility chapter of this document, **Dependent Children of a deceased Employee (a surviving dependent child**) may continue their coverage under this Plan after the death of the Employee, if the Dependent Children are otherwise eligible, until the end of the month in which the Employee would have turned age 55.

Disabled/Disability: The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Disabled Employee: Means an Employee who is on disability and inactive with an Employer participating under the Plan.

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

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: Your lawful Spouse and your Dependent Child(ren). An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility chapter for further information. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Eligible Medical, Dental and/or Vision Expenses: Expenses for medical, dental and/or vision services or supplies, but only to the extent that they are Medically Necessary, as defined in this Definitions chapter; and the charges for them are Allowed Charge, as defined in this Definitions chapter; and coverage for the services or supplies is not excluded, as provided in the Medical, Dental and Vision Exclusions chapters; and the Maximum Plan benefits for those services or supplies has not been reached.

Emergency Care: Medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical or dental attention could reasonably be expected to result in any of the following:

1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Services: means with respect to an emergency medical condition (defined below), a medical screening examination **within the emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver a newborn child (including the placenta).
- The term "**emergency medical condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

- The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed by a participating Employer of the Fund who is eligible to enroll for coverage under the Plan.

Employer: A participating Employer of the Fund.

Enroll, Enrollment: The process of completing and submitting an online enrollment indicating that coverage by the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility chapter for details regarding the mechanics of enrollment.

Essential Health Benefits: health benefits as required under federal law for self-funded ERISA plans.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Medical Plan Exclusions and Dental Plan Exclusions and Vision Plan Exclusions chapters, for which the Plan does **not** provide Plan benefits.

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility chapter.

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

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; **and** written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; **or** indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; **and** it has not been granted at the time the service or supply is prescribed or provided; **or a** current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will **<u>not</u>** be considered Experimental and/or Investigational if it is:
   - Approved by the FDA as an "investigational new drug for treatment use;" **or**
   - Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; **or**
   - Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was **<u>not</u>** approved for general use, **and** the FDA has **<u>not</u>** determined that such drug should not be prescribed for a given type of cancer.
5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

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

1. Medical or dental records of the Covered Individual;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information" and "American Hospital Formulary Service;"

5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or clinical policy bulletins of major insurance companies in the U.S. such as Aetna, CIGNA, or Milliman Care Guidelines (MCG), or the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

See also the coverage for "**Routine Costs Related to Clinical Trials**" in the Schedule of Medical Benefits.

To determine how to obtain a Precertification of any procedure that might be deemed to be Experimental and/or Investigational, see the Precertification Review section of the Utilization Management chapter.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Federal Legend Drugs: See the definition of Prescription Drugs.

Fluoride: A solution applied to the surface of teeth or a prescription drug (usually in pill form) to prevent dental decay.

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

Formulary: A list of drug products, including strength and dosages, available for use by Plan Participants.

Fund: IBEW/Western Utilities Health and Welfare Trust Fund.

Genetic Counseling: Counseling services provided before or in the absence of Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services include physician-prescribed therapy for a child who is not walking or talking at the expected age.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Outpatient Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, as those terms are defined in this Definitions chapter.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Nurse Practitioner, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, optometrist or optician for vision plan benefits, or Acupuncturist who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility, as those terms are defined in this Definitions chapter.

Health Factor: The term, as defined under the HIPAA Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market means any of the following eight health related factors: health status, medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Heath Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare; or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
   - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
   - It has a full-time administrator.
   - It is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
   - It maintains written clinical records of services provided to all patients.
   - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
   - Its employees are bonded.
   - It maintains malpractice insurance coverage.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must meet one of the following tests:

1. It is approved by Medicare; **or** is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; **or**
2. If licensing is not required, it meets all of the following requirements:
   - It provides 24 hour-a-day, 7 day-a-week service.
   - It is under the direct supervision of a duly qualified Physician.
   - It has a full-time administrator.
   - It has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
   - The main purpose of the agency is to provide Hospice services.
   - It maintains written records of services provided to the patient.
   - It maintains malpractice insurance coverage.

A Hospice that is part of a Hospital, as defined in this chapter, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that:

1. Is accredited by The Joint Commission (TJC); and
2. Is approved by Medicare as a Hospital; and
3. Provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.

A hospital may include facilities for Behavioral Health treatment that are licensed and operated according to law. Any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Subacute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or the aged shall **not** be regarded as a Hospital for any purpose related to this Plan.

IBEW: means International Brotherhood of Electrical Workers.

Illness: Any bodily sickness or disease, including any congenital abnormality of an eligible newborn child, as diagnosed by a Physician and as compared to the person's previous condition. See the Maternity row in the Schedule of Medical Benefits for limitations on coverage for a pregnant dependent child.

Impression: A negative reproduction of the teeth and gums, from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited metabolic disorders are also referred to an inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an inherited metabolic disorder under this Plan. See also Medical Foods.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing.

Inlay: A Restoration made to fit a prepared tooth cavity and then cemented into place. See the definition of Restoration.

In-Network Services: Services provided by a Health Care Provider that is a member of the Fund's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Investigational: See the definition of Experimental and/or Investigational.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Maximum Plan Benefits: The maximum amount of benefits payable by the Fund (and described in the Medical Plan Options chapter, Dental Expense Coverage chapter or Vision Plan chapter of this document) on account of medical, dental and/or vision expenses incurred by any covered Plan Participant under this Plan

- **Limited Overall Maximum Plan Benefits** are the maximum amount of benefits payable on account of certain covered medical, dental or vision services or supplies by the Fund during the entire time a Plan Participant is covered under this Plan and any previous medical, dental or vision expense plan provided by the Fund. The services or supplies that are subject to Limited Overall Maximum Plan benefits and the limits of those benefits are identified in the Schedule of Medical Benefits.
- **Annual Maximum Plan Benefits** are the maximum amount of benefits payable each Calendar Year on account of certain medical, dental and/or vision expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan and any previous medical, dental and/or vision plans provided by the Fund.

Medical Foods: Modified low protein foods and metabolic formulas as described here:

a. Modified Low Protein foods are foods that are formulated to be consumed or administered through the gastrointestinal tract and are processed or formulated to contain less than one gram of protein per unit of serving and are administered for the medical and nutritional management of a person who has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder.
b. Metabolic Formulas are solutions consumed or administered through the gastrointestinal tract and are processed or formulated to be deficient in one or more nutrients present in typical food products and are administered because a person has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder. See the definition of inherited metabolic disorder.
c. Medical Foods are NOT natural foods low in protein and/or galactose, spices, flavorings, or foods or formulas required by persons who do not have inherited metabolic disorders as that term is defined in this document.

Medically Necessary:

A. A medical, dental or vision 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 <u>all</u> of the following requirements:
        - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
        - It is not provided solely for the convenience of the patient, Physician, 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 or dental service or supply will be considered to be "Appropriate" if:

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

C. A medical or dental or vision 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 or Vision Provider may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental or vision coverage provided by the Fund.

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

F. A medical or dental or vision 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 medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

H. A medical or dental or vision 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.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a midwife or certified as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea.

Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-network: See Out of Network.

Non-Participating Provider/Non PPO: A Health Care Provider who **does not participate** in the Plan's Preferred Provider Organization (PPO), also called Out-of-Network.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid

in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a Physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license, and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. Neither a telephone discussion with a Physician or other Health Care Practitioner nor a visit to a Health Care Practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an Office Visit for the purposes of this Plan.

Onlay: An Inlay Restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Open Enrollment Period: The period during which Participants in the Plan may select among the alternate health benefit programs that are offered by the Plan. The Plan's annual Open Enrollment Period is described in the Eligibility chapter of this document.

Orthodontics, Orthodontia: The science of the movement of teeth in order to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism or Retrognathism. See the definitions of Prognathism and Retrognathism.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Out-of-Network Services: Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Out-of-Pocket Maximum: The Out-of-Pocket Maximum is the maximum amount of coinsurance for eligible expenses under the Premium Health Plan, Premium Plus Plan, Comprehensive Health Plan or Outpatient Prescription Drug Benefit that each covered person or family is responsible for paying during a Calendar Year before the coinsurance required by the Fund ceases to apply. When the Out-of-Pocket Maximum is reached, the Fund will pay more toward covered expenses for the remainder of the Calendar Year. The Plan's deductible, copays, expenses for medical services or supplies that are not covered by the Fund, and all charges in excess of the Allowed Charge as determined by the Plan Administrator or its designee **do not count** toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum on Coinsurance is not the same as the Out-of-Pocket Limit. See also **Out-of-Pocket Limit** explained in the Medical Plan Options chapter.

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are **not** incurred.

Partial Denture: A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.

Participant: means each Active Employee and his/her eligible Dependents, if any, each disabled Employee and his/her Dependents, if any, and any COBRA Qualified Beneficiaries.

Participating Provider: A Health Care Provider who participates in the Fund's Preferred Provider Organization (PPO).

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to

improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform activities of daily living such as walking and getting in and out of bed.

Physician: 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 or her license. See the "Physician and Other Health Care Practitioner Services" row of the Schedule of Medical Benefits for the Comprehensive Health Plan for information on which types of providers are considered Primary Care Physicians (PCP) and which are considered Specialists under that Plan. See also the term Health Care Practitioner.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter.

Plan, This Plan: The health and welfare programs, benefits and provisions described in this document as provided by the IBEW/Western Utilities Health and Welfare Trust Fund.

Plan Administrator: The Board of Trustees who has the fiduciary responsibility for the overall administration of the Plan.

Plan Sponsor or Board of Trustees: Means the Board of Trustees as defined in and provided by the Trust Agreement establishing the IBEW/Western Utilities Health and Welfare Trust Fund.

Plan Year: The 12-month period from January 1 to December 31 designated to be the Plan Year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Pre-Admission Testing: Laboratory tests and x-rays and other Medically Necessary tests performed on an out-patient basis prior to a scheduled hospital admission or outpatient surgery.

Precertification: Precertification is a review procedure performed by the Utilization Management Company **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and Medically Necessary.

Preferred Provider Organization (PPO): A group or network of Health Care Providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drugs:** Any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution—Federal Law prohibits dispensing without prescription."
2. **Other Prescription Drugs:** Drugs that require a prescription under state law but not under federal law.
3. **Compound Drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Preventive Services/Preventive Care Benefits: are defined under the Patient Protection and Affordable Care Act (Health Care Reform) and include recommended services rated as "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control & Prevention (CDC), and preventive care and screenings for women and children as recommended by the Health Resources and Services Administration (HRSA).

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Prophylactic, Prophylactic Surgery: Prophylactic means preventive. Prophylactic Surgery is a surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on Genetic Information or Genetic Testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman. Plan Participants should use

the Plan's Precertification procedure to determine if a proposed prophylactic service is medically necessary and could be considered payable by the Plan.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a Dentist or Dental Hygienist.

Prosthesis (Dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs and heart pacemakers. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Provider: See the definition of Health Care Provider.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child.

Reasonable Access: This means the first available appointment for the following:

- **Emergency Care:** life-threatening health condition. Not appropriate for provider office. Care typically not appropriate for an office visit and patient should seek immediate emergency care such as in an emergency room.
- **Urgent Care:** recent onset of acute non-life threatening symptoms that need prompt but not immediate care. Access to provider within 24 hours or referral to or use of an urgent care facility. *Examples: persistent vomiting, prolonged diarrhea, minor fracture, minor laceration, fever.*
- **Non-Urgent Symptomatic Care:** non-acute and non-life threatening, bothersome or illness/disabling condition has persisted for more than a week. Access to provider within three to seven days. *Examples: rash, fatigue, persistent sore throat, cold/flu symptoms*.
- **Routine Care:** follow-up care after initial treatment. Access to provider within 14 days. *Examples: blood pressure recheck, medication regulation*.
- **Preventive/Wellness Care:** Access to provider within 30 days. *Examples: physical exams, immunizations, pap smear*.

NOTE:

- It is understood that some patients will not find the first available appointment to be convenient or desirable for their schedule.
- While the above timeframes are Reasonable Access guidelines, it may be that for some communities there are limited number of certain types of health care providers (e.g., specialty physicians) making the normative duration of time to obtain the first available appointment in that community exceed the access timeframes noted above.

Reconstructive Surgery: A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation and Habilitation (as defined in this chapter) is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ

on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

Residential Treatment Program/Facility/Care: is a non-acute hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a residential treatment facility and contracted with the PPO network. Licensure requirements for this residential level of care may vary by state.

Restoration: A broad term applied to any filling, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were Medically Necessary and/or if the charges for them are Allowed Charges.

Root Canal (Endodontic) Therapy: Treatment of a tooth having a damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Scale: To remove calculus (tartar) and stains from the teeth with special instruments.

Second Opinion: A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Service Area: The geographic area serviced by the In-Network Health Care Providers who have agreements with the Plan's PPO. See the chapter on Medical Networks for additional information.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by The Joint Commission (TJC) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled or custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, and
7. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors.

Spouse: An employee's Spouse means a person of the **opposite gender or same gender** who is legally married under State law. The Plan follows the IRS guidance that a same gender couple is married for federal tax purposes if the couple was married in a state that allows same gender marriage, regardless of the laws of the state in which the married couple resides or the foreign jurisdiction in which the individuals' marriage was entered into. The Plan may require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse (when legal separation is permitted by state law), a domestic partner, a civil union, or a divorced former Spouse of an employee, a common law marriage, or a spouse of a Dependent Child. As discussed in the Eligibility chapter of this document, Dependents of a deceased Employee (surviving Spouse or Dependent child) may continue their coverage under this Plan after the death of the Employee, if the Dependents are otherwise eligible, until the end of the month in which the Employee would have turned age 55.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, generally not to exceed 60 days, to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

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

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability subchapter in the chapter on Coordination of Benefits for an explanation of how the Fund may use the right of subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Fund may recover medical and/or dental benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit. See also the definition of Tortfeasor.

Substance Abuse/Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) under the codes (291.0-292.9 or 303.0-305.9). See the definition of Behavioral Health Disorder.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits.

When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan's benefit:

1. Allowances for multiple surgeries through the same incision or operational field:	Primary procedure	100% of Allowed Charge
	Secondary and additional procedures	50% of Allowed Charge per procedure
2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:	First site primary procedure	100% of Allowed Charge
	First site secondary and additional procedures	50% of Allowed Charge per procedure
	Second site primary and additional procedures	50% of Allowed Charge per procedure

Surgical Assistant: See Certified Surgical Assistant.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. For further information, see the definition of Occupational, Physical and Speech Therapy.

Third Opinion: A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing Surgery or receiving a medical service, provided by the Plan when the Second Opinion indicates that the recommended Surgery or medical service is not Medically Necessary.

Topical: Painting the surface of teeth as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Tort, Tortfeasor: A civil wrong or injury, typically arising from a negligent or intentional act of an individual, who is called a tortfeasor. See also the definition of Subrogation.

Total Disability, Totally Disabled: The inability of a covered Employee to perform all the duties of his or her occupation with a participating Employer of the Fund as a result of a non-occupational illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of Disabled.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissues or cells (such as bone marrow, stem cells, or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are always allogenic.
- **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan, except as determined to be an FDA-approved use of xenographic tissue such as a porcine heart valve.

See the Schedule of Medical Benefits and the Exclusions chapter for additional information regarding Transplants. See also the Utilization Management chapter of this document for information about precertification requirements for transplantation services.

Trust or Trust Agreement: means the Restated Agreement and Declaration of Trust establishing the IBEW/Western Utilities Health and Welfare Trust Fund, as amended from time to time.

Union: means the Local Union No. 57 and No. 125 of the International Brotherhood of Electrical Workers (IBEW) or any other Union admitted to the Fund as provided for in the Trust Agreement.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that require Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Management (UM): A managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation. Utilization Management services (sometimes referred to as UM services, UM program, Utilization Review services, UR services, Utilization Management and Review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan.

Utilization Management Company: The independent utilization management organization, staffed with licensed health care professionals, operating under a contract with the Fund to administer the Plan's Utilization Management services.

Visit: See the definition of Office Visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined under the Plan to be Medically Necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of Well Baby Care is described under Preventive Services Programs in the Wellness row of the Schedule of Medical Benefits.

You, Your: When used in this document, these words refer to the Employee who is covered by the Plan. They do **not** refer to any Dependent of the Employee.

19. SUMMARY OF LIFE, AD&D, AND DEPENDENTS LIFE INSURANCE

This chapter outlines/summarizes some of the benefits for Employee Basic Life Insurance, Accidental Death and Dismemberment (AD&D) Insurance, Dependent Life Insurance and Voluntary Supplemental Life Insurance as provided by an independent Life Insurance Company (whose name and address are listed on the Quick Reference Chart in the front of this document). Since this chapter is only a summary of benefits, you should refer to the Group Certificate of Insurance and documents provided to you by the Life Insurance Company.

If there is a difference between the information contained in this chapter and the documents of the Life Insurance Company, the Life Insurance Company documents will prevail.

ELIGIBILITY FOR LIFE INSURANCE BENEFITS

You are eligible for life insurance if you are a member of the class defined below.

- **CLASS ONE:** All active, full-time Union Employees in a job class covered by a Collective Bargaining Agreement of a participating Employer regularly working a minimum of 20 hours per week. Class One employees are also eligible for Accidental Death and Dismemberment Insurance.
- **CLASS TWO:** All Employees under the age of 65 who became disabled on or after January 1, 2008 and meet the definition of disability under the employer-sponsored long term disability insurance plan and who **are not approved for Waiver of Premium benefits** under the life insurance policy.
- **CLASS THREE:** All Employees under the age of 65 who became disabled prior to January 1, 2008 and meet the definition of disability under the employer-sponsored long term disability insurance plan and who **are not approved for Waiver of Premium benefits** under the life insurance policy.

This chapter outlines the Life Insurance and Accidental Death and Dismemberment benefits for Class One. For benefits for Class Two and Class Three, contact the Life Insurance Company.

Class One Eligibility Waiting Period

The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. It will be extended by the number of days you are not in Active Service.

- If you were hired on or before the Policy Effective Date of January 1, 2008: The first of the month after or coinciding with your date of employment.
- If you were hired after the Policy Effective Date of January 1, 2008: The first of the month after or coinciding with your date of employment.
- For Class Two and Class Three disabled individuals, there is no waiting period.

LIFE INSURANCE BENEFITS FOR CLASS ONE

If an insured is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in his or her insurance due to the class change will be effective on the date of the change in class.

EMPLOYEE BENEFITS	
Basic Benefit	2 times your Annual Base Compensation rounded to the next higher $1,000, if not already a multiple thereof.
Guaranteed Issue Amount:	the lesser of 2 times Annual Base Compensation or $250,000
Maximum Benefit:	the lesser of 2 times Annual Base Compensation or $250,000
Voluntary Benefit	1, 2, 3 or 4 times your Annual Base Compensation rounded to the next higher $1,000, if not already a multiple thereof.
Guaranteed Issue Amount:	the greater of a) or b) below:
	a) the lesser of 1 times Annual Base Compensation or $700,000, or
	b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	the lesser of 4 times Annual Base Compensation or $700,000
Age Based Reductions	When you are age 70 or older, your Life Insurance Benefit will reduce to: 50% of the Life Insurance Benefit at age 70
Terminal Illness Benefit	
Maximum Benefit:	$500,000

Automatic Increase Feature

If you or your Insured Spouse's Voluntary Life Insurance Benefit is based on Annual Base Compensation , it will automatically increase. The amount of the increase may be up to $25,000. It will automatically increase, subject to the conditions below.

Conditions for Automatic Increase:

1. you provide the Life Insurance Company with the required notice of an increase in Annual Base Compensation ;
2. you are in Active Service on the effective date of the increase; and
3. the total benefit for you or your Spouse does not exceed the Guaranteed Issue Amount.

If you are not in Active Service on that date, your benefit will not increase until you return to Active Service.

You or your Spouse will be required to satisfy the Insurability Requirement for an increased amount if:

1. you initially elect a Voluntary Life Insurance Benefit that is less than or equal to the Guaranteed Issue Amount and your benefit plus the automatic increase would exceed it; and
2. you have not been approved by the Life Insurance Company for a Voluntary Life Insurance Benefit in excess of the Guaranteed Issue Amount.

An Automatic Increase will become effective on the date of your increase in Annual Base Compensation , or if later, the date the Life Insurance Company approves any required Insurability Requirement.

If you or your Spouse are initially approved for a Voluntary Life Insurance Benefit in excess of the Guaranteed Issue Amount, it will not increase in excess of the Maximum Benefit Amount.

You or your Spouse may stop the Automatic Increase Feature at any time. If you or your Spouse stop the feature, it may not be restarted at a later date.

Re-enrollment Period

During a Re-enrollment Period, if you are currently insured under the Voluntary Life Insurance portion of this Policy you may increase your Voluntary Life Insurance Benefit by one Benefit Level, as long as the total Benefit Amount does not exceed the Guaranteed Issue Amount, without satisfying the Insurability Requirement. Benefit Levels and Guaranteed Issue Amounts are shown above. If you are eligible for the Voluntary Life Insurance portion of this Policy but were not previously enrolled, you may become insured under the Policy for an amount equal to one Benefit Level without satisfying the Insurability Requirement. Such increases will become effective on the Policy Anniversary following the Reenrollment Period.

You may increase coverage, and if you are eligible but have not enrolled, may become insured, for a Benefit in excess of amounts described above, only if you satisfy the Insurability Requirement. Any excess amounts will be effective on the later of the Policy Anniversary following the Re-enrollment Period or the date the Life Insurance Company agrees in writing to insure you.

You may reduce Insurance Benefits at any time. A request for a Benefit reduction received during a Reenrollment Period will become effective on the Policy Anniversary following the Re-enrollment Period. Any other Benefit reduction will be effective on the date the Life Insurance Company receives the completed change form.

Life Status Changes

Within 31 days after a Life Status Change, if you or your Spouse are currently insured under the Voluntary Life Insurance portion of this Policy you may increase your Voluntary Life Insurance Benefit by one Benefit Level, as long as the total Benefit Amount does not exceed the Guaranteed Issue Amount, without satisfying the Insurability Requirement. Benefit Levels and Guaranteed Issue Amounts are shown above. Such increases will be effective on the date that the Life Insurance Company receives the completed request for a Benefit increase.

If you or your Spouse are eligible for the Voluntary Life Insurance portion of this Policy but were not previously enrolled, you may become insured under the Policy by satisfying the Insurability Requirement. Your insurance will be effective on the date the Life Insurance Company agrees in writing to insure you.

You or your Spouse may increase coverage for a Benefit in excess of amounts described above, only if you satisfy the Insurability Requirement. Any excess amounts will be effective on the date the Life Insurance Company agrees in writing to insure you.

An Employee may reduce Insurance Benefits at any time. The reduced amount will be effective on the date the Life Insurance Company receives the completed change form.

SPOUSE BENEFITS	
Basic Benefit	$30,000
Guaranteed Issue Amount:	$30,000
Voluntary Benefit	1 or 2 times the Employee's Annual Base Compensation rounded to the next higher $1,000, if not already a multiple thereof
Guaranteed Issue Amount:	An amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	the lesser of 2 times the Employee's Annual Base Compensation or $200,000
Terminal Illness Benefit	
Maximum Benefit:	75% of the Maximum Benefit applicable to your Life Insurance Benefits.
DEPENDENT CHILD BENEFITS	
Basic Benefit	The maximum benefit for a child is $15,000.

All Dependent Child benefits are Guaranteed Issue.

FORMER EMPLOYEE BENEFITS	
Amount of Insurance	An amount equal to the Voluntary Life Insurance Benefit in force on the date he or she no longer qualifies as an Employee less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance.
Maximum Benefit Period:	To Age 70.
Terminal Illness Benefit	
Maximum Benefit:	$500,000
SPOUSE OF FORMER EMPLOYEE BENEFITS	
Amount of Insurance	An amount equal to the Voluntary Life Insurance Benefits in force on the date the Former Employee no longer qualifies as an Employee
Maximum Benefit:	To Age 70.
Terminal Illness Benefit	
Maximum Benefit:	75% of the Maximum Benefit applicable to your Life Insurance Benefits.
FORMER SPOUSE BENEFITS	
Amount of Insurance	An amount equal to the Voluntary Life Insurance Benefits in force on the date the he or she no longer qualifies as a Spouse.
Maximum Benefit:	To Age 70
Terminal Illness Benefit	
Maximum Benefit:	75% of the Maximum Benefit applicable to your Life Insurance Benefits.

DEFINITIONS RELATED TO LIFE INSURANCE BENEFITS

Dependent Child

Your unmarried child who meets the following requirements.

1. A child from live birth but less than 26 years old;
2. A child who is 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity. Proof of the child's condition and dependence must be submitted to the Life Insurance Company within 31days after the date the child ceases to qualify as a Dependent for the reasons listed above. During the next two years, the Life Insurance Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Life Insurance Company may require proof no more than once a year.

The term "child" means:

a. your natural child;

b. your legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;

c. a stepchild born to your Spouse and who is living with and financially dependent upon you.

Disabled

You are Disabled, if, because of Injury or Sickness, you are unable to perform all the material duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

Spouse

Your current lawful spouse.

WHEN COVERAGE BEGINS

You, your Spouse and Dependent Children will be insured for an amount not to exceed the Guaranteed Issue Amount on the date you become eligible, if you are not required to contribute to the cost of this insurance.

You and your Spouse will be insured for an amount that exceeds the Guaranteed Issue Amount on the date the Life Insurance Company agrees in writing to provide this coverage. The Life Insurance Company will require an eligible person to satisfy the Insurability Requirement before they agree to insure him or her.

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and the Life Insurance Company. The effective date of this insurance depends on the date and amount of insurance elected.

If you elect coverage within 31 days after you become eligible to enroll or increase coverage, the Guaranteed Issue Amount will be effective on the latest of the following dates:

1. The Policy Effective Date.
2. The date you authorize payroll deduction for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

If you or your Spouse elect insurance in an amount that exceeds the Guaranteed Issue Amount or if your enrollment form is received more than 31 days after you become eligible to elect coverage, this insurance is effective on the date the Life Insurance Company agrees in writing to provide this coverage. The Life Insurance Company will require an eligible person to satisfy the Insurability Requirement before they agree to insure him or her.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date he or she qualifies as a Dependent Child.

If you are not in Active Service on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Service.

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage.

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service

If you are not in Active Service on the Policy Effective Date, you are not covered under the Policy. However, the Life Insurance Company agrees to provide a death benefit equal to the lesser of:

1. the amount due under this Policy (without regard to the Active Service provision), or
2. the amount that would have been due under the Prior Plan had it remained in force.

The benefit amount will be reduced by any amount paid by the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.

These special terms will end on the earliest of the following dates:

1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the When Coverage Ends provision;
3. 12 months after the Policy Effective Date; or
4. the last day you would have been covered under the Prior Plan if that plan was still in force.

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date the Life Insurance Company terminates the Policy;
3. the date you, your Spouse or Dependent Children are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service;
6. for an Employee, Spouse or Dependent Child, the date the Employer cancels participation under the Policy; and
7. the date your coverage ends, for any insured Spouse or Dependent Child.

WHEN COVERAGE CONTINUES

Continuation for Family Medical Leave

If you are an Employee and your Active Service ends due to an Employer approved family medical leave, your insurance will continue for up to 12 weeks if the required premium is paid.

Continuation for Disability for Employees over Age 60

If you become Disabled and are age 60 or over, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:

1. The date you are no longer Disabled.
2. The date you are Disabled for 12 consecutive months.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated by the Life Insurance Company.

Amount of Insurance

If you die while you are Disabled and coverage is continued under this provision, the Life Insurance Company will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while coverage is continued under this provision. The Life Insurance Company will pay benefits only if due proof of your continuous Disability is received within one year of the date of the loss.

“Disability”/”Disabled” means because of Injury or Sickness you are unable to perform all the material duties of your Regular Occupation; or are receiving disability benefits under the Employer’s plan.

“Regular Occupation” means the occupation you routinely perform at the time the Disability begins. The Life Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If you become Disabled and are less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date you are no longer Disabled.
2. The date you fail to qualify for Waiver of Premium or fail to provide proof of Disability as indicated under Waiver of Premium.

Amount of Insurance

If you die while you are Disabled and coverage is extended under this provision, the Life Insurance Company will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. The Life Insurance Company will pay benefits only if due proof of your continuous Disability is received within one year of the date of the loss.

"Disability"/"Disabled" means because of Injury or Sickness you are unable to perform all the material duties of your Regular Occupation; or are receiving disability benefits under the Employer's plan.

"Regular Occupation" means the occupation you routinely perform at the time the Disability begins. The Life Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Waiver of Premium (*Applies to Class One only*)

If you submit satisfactory proof that you have been continuously Disabled for 6 months, coverage will be extended up to Social Security Normal Retirement Age.

Such proof must be submitted to the Life Insurance Company no later than 3 months after the date the Waiver Waiting Period ends. Premiums will be waived from the date the Life Insurance Company agrees in writing to waive premiums for you.

After premiums have been waived for 12 months, they will be waived for future periods of 12 months, if you remain Disabled and submit satisfactory proof that Disability continues. Satisfactory proof must be submitted to the Life Insurance Company 3 months before the end of the 12-month period.

Amount of Insurance

If you die while you are Disabled and coverage is continued under this provision, the Life Insurance Company will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. The Life Insurance Company will pay benefits only if due proof of your continuous Disability is received within one year of the date of the loss.

Termination of Waiver

Your insurance will end on the earliest of the following dates.

1. The date you are no longer Disabled.
2. The date you refuse to submit to any physical examination required by the Life Insurance Company.
3. The last day of the 12-month period of Disability during which you fail to submit satisfactory proof of continued Disability.
4. Social Security Normal Retirement Age.

"Disability"/"Disabled" means because of Injury or Sickness you are unable to perform all the duties of your regular occupation. After 24 months, you are considered disabled if because of an injury or sickness you are unable to perform all of the materials duties of any occupation for which you are reasonably qualified based on education, training or experience.

Portability Options

For Employees

If your coverage under the Policy ends prior to age 70, for any of the following reasons:

a. termination of employment; or
b. termination of membership in an eligible class under the Policy;

Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Life Insurance Company and pay the required premium. If you continue coverage, coverage for your Spouse or Dependent Child may also be continued by you. Your Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:

a. within 31 days of your termination of employment or membership in an eligible class under the Policy; or
b. during the time that you have to exercise the Conversion Privilege.

Coverage under this option may not be elected at a later date.

When applying for this option, you must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of your estate.

When coverage is continued under this option, you become a Former Employee. Your Spouse becomes a Spouse of a Former Employee. Your Dependent Child becomes a Dependent Child of a Former Employee.

If you, as a Former Employee, later acquire a Spouse or Dependent Child, you may elect coverage for them. You must apply to the Life Insurance Company and pay the required premium. Coverage for your Spouse or Dependent Child will be effective on the date the Life Insurance Company agrees in writing to insure them. The Life Insurance Company may require that your Spouse or Dependent Child satisfy the Insurability Requirement before they agree to insure them.

Coverage will end on the earliest of the following dates.

a. The date the Life Insurance Company cancels coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date an Insured reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Spouses

If prior to age 70, a Spouse is:
a. legally separated, divorced; or
b. widowed
from an insured Employee or Former Employee, Life Insurance Benefits may be continued. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option. The Spouse must apply to the Life Insurance Company and pay the required premium.

A Spouse who continues coverage may also continue coverage for a Dependent Child. The Dependent Child must be covered under the Policy on the date coverage would otherwise end. A Spouse must elect to continue insurance under this option within 31 days after coverage ends. Coverage may not be elected at a later date.

When applying for this option, a Spouse must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Spouse's estate.

When coverage is continued under this option, the Spouse becomes a Former Spouse. A separate certificate of insurance will be issued to the Former Spouse. Coverage will be effective on the date after coverage as a Spouse ends if the required premium is paid.

Coverage will end on the earliest of the following dates.

a. The date the Life Insurance Company cancels coverage for all Former Spouses.
b. The end of the period for which premiums are paid.
c. The date the Former Spouse reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for a Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit

If an Insured dies, the Life Insurance Company will pay the Life Insurance Benefit in force for that Insured on the date of his or her death.

Accelerated Benefits

Any benefits payable under this Accelerated Benefits provision will reduce the Death Benefit payable for Life Insurance. Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision.

Terminal Illness Benefit

The Life Insurance Company will pay a Terminal Illness Benefit if they determine you or your Spouse are Terminally Ill. The amount of this benefit is 75% of the Life Insurance Benefit in effect for you or your Spouse on the date the Life Insurance

Company determines you are Terminally Ill up to the Maximum Benefit Amount shown in your Schedule of Benefits for this option. The Terminal Illness Benefit is payable only once in an Insured's lifetime.

Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, the Life Insurance Company will require you to submit the following proof.

1. A written diagnosis and prognosis by two Physicians licensed to practice in the United States.
2. Supportive evidence satisfactory to the Life Insurance Company, including but not limited to radiological, histological or laboratory reports documenting the Terminal Illness.

The Life Insurance Company may require, at their expense, you to be examined and a review of the documented evidence, by a Physician of their choice.

"Terminal Illness" means a person is diagnosed by a Physician to have a prognosis of 12 months or less to live.

Conversion Privilege for Life Insurance

If coverage ends for any reason except non-payment of premium, any Insured may apply for a conversion policy of life insurance.

The conversion insurance may be a type of life insurance currently being offered for conversion by the Life Insurance Company at your age and in the amount requested. It may not be term insurance and it may not be for an amount greater than the Life Insurance Benefits in force under the Policy. Conversion life insurance will not provide accident, disability or other benefits.

However, if coverage ends because the Policy is terminated or amended to terminate any class of Insureds, or the Employer cancels participation under the Policy, coverage cannot be converted unless you have been insured under the Policy for at least 3 years. In this case, the amount of conversion insurance will be the lesser of Life Insurance Benefit in force under the Policy or $10,000.

To apply for conversion insurance, you must submit an application to the Life Insurance Company and pay the required premium within 31 days after coverage under the Policy ends. Evidence of insurability is not required. Premium for the conversion insurance will be based on your age and class of risk and the type and amount of coverage issued.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends, if your application is received by the Life Insurance Company and the required premium is paid on that date.

If you die during the 31 day conversion period, the Death Benefit will be paid under the Policy regardless of whether you applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any benefits payable for that type and amount of insurance under the Policy.

Extension of Conversion Period

If you are eligible for conversion insurance and are not notified of this right at least 15 days prior to the end of the 31 day conversion period, the conversion period will be extended. You will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to you by your Employer or mailed to your last known address as reported by your Employer.

If you die during the extended conversion period, but more than 31 days after your coverage under the Policy terminates, Life Insurance Benefits will not be paid under the Policy. If your application for conversion insurance is received by the Life Insurance Company and the required premium is paid, Life Insurance Benefits will be payable under the conversion insurance.

Prior Conversion Limitation

If you are covered under a life insurance conversion policy previously issued by the Life Insurance Company under the Policy, you will not be eligible to exercise this Conversion Privilege unless the prior coverage has ended. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Life Insurance Benefits based on age or a change in class.

LIFE INSURANCE EXCLUSIONS

If an Insured commits suicide, while sane or insane, within 2 years from the date the Insured's insurance under the Policy becomes effective, Voluntary Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to you if you were covered under the Prior Plan for more than two years. If you were not insured for two years under the Prior Plan, credit will be given for the time you were insured.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under your certificate, no refund of premiums will be paid.

CLAIM PROVISIONS

Notice of Claim

Written notice of claim, or notice by any other electronic/telephonic means authorized by the Life Insurance Company, must be given to within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Life Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at the Life Insurance Company's home office in Philadelphia, Pennsylvania or to their agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Written notice, or any other electronic/telephonic means authorized by the Life Insurance Company, of a diagnosis of a Terminal Illness on which claim is based must be given to the Life Insurance Company within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice, or any other electronic/telephonic means authorized by the Life Insurance Company, was given as soon as reasonably possible.

Claim Forms

When the Life Insurance Company receives notice of claim, they will send claim forms for filing proof of loss. If the Life Insurance Company does not send claim forms within 15 days after notice is received by the Life Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Life Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision

If you fail to cooperate with the Life Insurance Company in their administration of your claim, the Life Insurance Company may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Employer is required to cooperate with the Life Insurance Company in the review of claims and applications for coverage. Any information the Life Insurance Company provides to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss

You must provide written proof of loss to the Life Insurance Company, or proof by any other electronic/telephonic means authorized by the Life Insurance Company, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Life Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Life Insurance Company, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Life Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

Written proof, or any other electronic/telephonic means authorized by the Life Insurance Company, of loss for Accelerated Benefits must be furnished 90 days after the date of diagnosis. This proof must describe the occurrence, character and diagnosis for which claim is made.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If it is not reasonably possible to submit proof of loss within these time periods, the Life Insurance Company will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

Time of Payment

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installment payments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable

Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. The Life Insurance Company may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed the Life Insurance Company otherwise in writing. However, any payment made by the Life Insurance Company prior to notice of the Insured's death shall discharge the Life Insurance Company of any benefit that was paid.

All other benefits unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at your death will, at the Life Insurance Company's option, be paid either to your beneficiary or to the executor or administrator of your estate.

If the Life Insurance Company pays benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, they may pay up to $1,000 to a relative by blood or marriage whom the Life Insurance Company believes is equitably entitled. This good faith payment satisfies the Life Insurance Company's legal duty to the extent of that payment.

Change of Beneficiary

You may change your beneficiary at any time by giving written notice to the Employer or to the Life Insurance Company. The beneficiary's consent is not required for this or any other change which you may make unless your designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Employer or the Life Insurance Company. When this form is received, it will take effect as of the date of the form. If you die before the form is received, the Life Insurance Company will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy

The Life Insurance Company may, at their expense, exercise the right to examine any person for whom a claim is pending as often as the Life Insurance Company may reasonably require. Also, the Life Insurance Company may, at their expense, require an autopsy unless prohibited by law.

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Life Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship

You have the right to choose any Physician who is practicing legally. The Life Insurance Company will in no way disturb the Physician/patient relationship.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Life Insurance Company. You must complete your claim according to directions provided by the Life Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Plan Administrator.

The Plan Administrator has appointed the Life Insurance Company as the named fiduciary for adjudicating claims for benefits under the Life Insurance Plan, and for deciding any appeals of denied claims. The Life Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the

Plan, and to make any related findings of fact. All decisions made by the Life Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Life Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Life Insurance Company may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Life Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in the case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Life Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Life Insurance Company will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Life Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Life Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Life Insurance Company within the review period. The Life Insurance Company's written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.

Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Life Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Life Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Any medical or vocational experts consulted by the Life Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Life Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Life Insurance Company may require more time to review your claim. If this should happen, the Life Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Life Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Accidental Death and Dismemberment Insurance benefits apply to Class One employees. Class 1 means all active, full-time Union Employees in a job class covered by a Collective Bargaining Agreement of a participating Employer regularly working a minimum of 20 hours per week.

SCHEDULE OF AD&D BENEFITS

This **Schedule of AD&D Benefits** shows maximums, benefit periods and any limitations applicable to benefits provided for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Employee's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

Eligibility Waiting Period:

The Eligibility Waiting Period is the period of time the Employee must be in a Covered Class to be eligible for coverage.

For Employees hired on or before the Policy Effective Date:	The first of the month after or coinciding with the date of hire
For Employees hired after the Policy Effective Date:	The first of the month after or coinciding with the date of hire

Time Period for Loss:

Any Covered Loss must occur within:	365 days of the Covered Accident

Maximum Age for Insurance: None

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum: 2 times Annual Base Compensation rounded to the next higher $1,000, if not already a multiple thereof, subject to a maximum of $250,000

Changes in the Covered Person's amount of insurance resulting from a change in the Employee's amount of Annual Base Compensation take effect, subject to any Active Service requirement, on the first day of the month following the change in Annual Base Compensation .

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	25% of the Principal Sum

AGE REDUCTIONS

A Covered Person's Principal Sum will be reduced to the percentage of his Principal Sum in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
70	50%

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the **Schedule of Covered Losses** and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE provides the Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the **Schedule of Covered Losses**.

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these **Additional Accident Benefits** shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

CHILD CARE CENTER BENEFIT	
Benefit Amount	3% of the Employee's Principal Sum subject to a maximum of $5,000 per year
Maximum Benefit Period	5 years but not beyond age 13 for each surviving Dependent Child
SEATBELT AND AIRBAG BENEFIT	
Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of $10,000
Airbag Benefit	5% of the Principal Sum subject to a Maximum Benefit of $10,000
Default Benefit	$1,000
SPECIAL EDUCATION BENEFIT	
Surviving Dependent Child Benefit	3% of the Principal Sum subject to a Maximum Benefit of $5,000
Maximum Number of Annual Payments For Each Surviving Dependent Child 4 Default Benefit	4
Default Benefit	$1,000
SPOUSE RETRAINING BENEFIT	
Benefit	3% of the Principal Sum subject to a Maximum Benefit of $5,000

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum:	1, 2, 3 or 4 times Annual Base Compensation rounded to the next higher $1,000, if not already a multiple thereof, subject to a maximum of $700,000
Spouse Principal Sum:	
Option 1	$30,000; or
Option 2	1 or 2 times Annual Base Compensation rounded to the next higher $1,000, if not already a multiple thereof, subject to a maximum of $200,000

Changes in the Covered Person's amount of insurance resulting from a change in the Employee's amount of Annual Base Compensation take effect, subject to any Active Service requirement, on the first day of the month following the change in Annual Base Compensation.

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	25% of the Principal Sum

AGE REDUCTIONS

A Covered Person's Principal Sum will be reduced to the percentage of his Principal Sum in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
70	50%

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the **Schedule of Covered Losses** and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE provides the Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the **Schedule of Covered Losses**.

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these **Additional Accident Benefits** shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

CHILD CARE CENTER BENEFIT	
Benefit Amount	3% of the Employee's Principal Sum subject to a maximum of $5,000 per year
Maximum Benefit Period	5 years but not beyond age 13 for each surviving Dependent Child
SEATBELT AND AIRBAG BENEFIT	
Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of $10,000
Airbag Benefit	5% of the Principal Sum subject to a Maximum Benefit of $10,000
Default Benefit	$1,000
SPECIAL EDUCATION BENEFIT	
Surviving Dependent Child Benefit	3% of the Principal Sum subject to a Maximum Benefit of $5,000
Maximum Number of Annual Payments For Each Surviving Dependent Child 4 Default Benefit	4
Default Benefit	$1,000
SPOUSE RETRAINING BENEFIT	
Benefit	3% of the Principal Sum subject to a Maximum Benefit of $5,000

GENERAL DEFINITIONS (Pertaining to AD&D Benefits)

Active Service

An Employee will be considered in Active Service with the Employer on any day that is either of the following:

1. one of the Employer's scheduled work days on which the Employee is performing his regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel;
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than sick leave, only if the Employee was in Active Service on the preceding scheduled workday.

A person other than an Employee is considered in Active Service if he is none of the following:

1. an Inpatient in a Hospital or receiving Outpatient care for chemotherapy or radiation therapy;
2. confined at home under the care of a Physician for Sickness or Injury;
3. Totally Disabled.

Age

A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under this Policy. Thereafter, it is his Age attained on his last birthday.

Aircraft

A vehicle which:

1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Annual Base Compensation

An Employee's annual earnings for normal work established by the Subscriber for his job classification, **excluding** commissions, bonuses or overtime.

Covered Accident

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. is not otherwise excluded under the terms of this Policy.

Covered Injury

Any bodily harm that results directly and independently of all other causes from a Covered Accident.

Covered Loss

A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the **Schedule of Covered Losses**;
3. suffered by the Covered Person within the applicable time period specified in the **Schedule of Benefits**.

Covered Person

An eligible person, as defined in the **Schedule of Benefits**, for whom an enrollment form has been accepted by the Life Insurance Company and required premium has been paid when due and for whom coverage under this Policy remains in force. The term Covered Person shall include, where this Policy provides coverage, an eligible Spouse.

Employee

For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.

Employer

The Subscriber and any affiliates, subsidiaries or divisions shown in the **Schedule of Covered Affiliates** and which are covered under this Policy on the date of issue or subsequently agreed to by the Life Insurance Company.

He, His, Him

Refers to any individual, male or female.

Hospital

An institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Covered Person incurs an expense.

Inpatient

A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term 'Inpatient' shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Nurse

A licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and who is not:
1. employed or retained by the Subscriber;
2. living in the Covered Person's household; or
3 a parent, sibling, spouse or child of the Covered Person.

Outpatient

A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.

Prior Plan

The plan of insurance providing similar benefits, sponsored by the Employer in effect immediately prior to this Policy's Effective Date.

Physician

A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the Subscriber;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of the Covered Person.

Sickness

A physical or mental illness.

Spouse

The Employee's lawful spouse.

Subscriber

Any participating organization that subscribes to the trust to which this Policy is issued.

Totally Disabled or Total Disability

Totally Disabled or Total Disability means either:

1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

You, Your

The person to whom the certificate is issued.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Subscriber Effective Date

Accident Insurance Benefits become effective for each Subscriber in consideration of the Subscriber's application, Subscription Agreement and payment of the initial premium when due. Insurance coverage for the Subscriber becomes effective on the Effective Date of Subscriber Participation.

Eligibility

An Employee becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the **Schedule of Benefits.**

A Spouse of an eligible Employee becomes eligible for any dependent insurance provided by this Policy on the later of the date the Employee becomes eligible and the date the Spouse meets the applicable definition shown in the **Definitions** section of this Policy.

No person may be eligible for insurance under this Policy as both an Employee and a Spouse at the same time.

Effective Date for Individuals

Basic Accidental Death and Dismemberment Benefits

Insurance becomes effective for an eligible Employee, subject to the **Deferred Effective Date** provision below, on the latest of the following dates:

1. the effective date of this Policy;
2. the date the Employee becomes eligible.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Insurance becomes effective for an eligible Employee who applies and agrees to make required contributions within 31 days of eligibility, and subject to the **Deferred Effective Date** provision below, on the latest of the following dates:

1. the effective date of this Policy;
2. the date the Employee becomes eligible;
3. the date the Life Insurance Company receives the Employee's completed enrollment form and the required first premium, during his lifetime.

Insurance becomes effective for an Employee's eligible dependents if the Employee applies and agrees to make required contributions within 31 days of the date his dependents become eligible and, subject to the **Deferred Effective Date** provision below, on the latest of the following dates:

1. the effective date of this Policy;
2. the date the Employee becomes eligible;
3. the date the Employee's insurance becomes effective;
4. the date the dependent meets the definition of Spouse;
5. the date the Life Insurance Company receives a completed enrollment form for Spouse coverage and the required first premium, during each dependent's lifetime.

Insurance becomes effective for a newborn Dependent Child automatically from the moment of the child's live birth. Insurance for that Dependent Child automatically ends 31 days later unless the Employee has a Spouse or other Dependent Children insured under this Policy or makes a request to cover the child and pays the required initial premium, during the child's lifetime.

DEFERRED EFFECTIVE DATE

Active Service

The effective date of insurance will be deferred for any Employee or any eligible Spouse who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date he returns to Active Service and the date coverage would otherwise have become effective.

Life Status Change

A Life Status Change is an event that the Employer determines qualifies an Employee to elect or increase accident insurance benefits for himself and his Spouse. Any change in benefit elections must be made within 31 days of a Life Status Change.

Any increases in benefits or added benefits elected under this Life Status Change provision will become effective on the first of the month following the Life Status Change.

The Subscriber should seek advice of its tax advisors if Employees may contribute to the cost of any insurance provided by this Policy with earnings not subject to Federal Income Tax. The Life Insurance Company cannot provide such advice nor offer any opinions on taxation or tax status of any contributions toward the cost of insurance.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

TERMINATION OF INSURANCE

The insurance on a Covered Person will end on the earliest date below:

1. the date this Policy or insurance for a Covered Class is terminated;
2. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
3. the last day of the last period for which premium is paid;
4. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy;
5. with respect to a Spouse, the date of the death of the covered Employee or the date of divorce from the covered Employee.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

CONTINUATION OF INSURANCE

Continuation for Family Medical Leave

Insurance for an Employee and Covered Dependents may be continued until the earliest of the following dates if: (a) an Employee is on an Employer-approved family medical leave; and (b) required premium contributions are paid when due.

1. for an Employer-approved family medical leave: 12 weeks in a consecutive 12-month period.

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the **Description of Benefits** Section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war;
5. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
6. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
7. in addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
   a. employed or retained by the Subscriber;
   b. providing homeopathic, aroma-therapeutic or herbal therapeutic services;
   c. living in the Covered Person's household;
   d. a parent, sibling, spouse or child of the Covered Person.

CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to the Life Insurance Company within 31 days after a Covered Loss occurs or begins or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible.

Notice can be given to the Life Insurance Company at their Home Office in Philadelphia, Pennsylvania, such other place as the Life Insurance Company may designate for the purpose, or to the Life Insurance Company's authorized agent. Notice should include the Subscriber's name and policy number and the Covered Person's name, address, policy and certificate number.

Claim Forms

The Life Insurance Company will send claim forms for filing proof of loss when they receive notice of a claim. If such forms are not sent within 15 days after the Life Insurance Company receives notice, the proof requirements will be met by submitting, within the time fixed in the Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision

Failure of a claimant to cooperate with the Life Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to the Life Insurance Company must be given to the Life Insurance Company at their office, within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which the Life Insurance Company is liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

The Life Insurance Company will pay benefits due under the Policy for any loss other than a loss for which the Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to the Life Insurance Company.

Payment of Claims

All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the **Beneficiary** provision and these Claim Provisions. All other proceeds payable under the Policy, unless otherwise stated, will be payable to the covered Employee or to his estate.

If the Life Insurance Company is to pay benefits to the estate or to a person who is incapable of giving a valid release, the Life Insurance Company may pay $1,000 to a relative by blood or marriage whom they believe is equitably entitled. Any payment made by the Life Insurance Company in good faith pursuant to this provision will fully discharge the Life Insurance Company to the extent of such payment and release the Life Insurance Company from all liability.

Physical Examination and Autopsy

The Life Insurance Company, at their own expense, has the right and opportunity to examine You and Your Spouse when and as often as they may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Beneficiary

The beneficiary is the person or persons You name or change on a form executed by You and satisfactory to the Life Insurance Company. This form may be in writing or by any electronic means agreed upon between the Life Insurance Company and the Subscriber. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy. Any Accidental Death Benefit payable at the death of your Spouse will be paid to You or Your estate.

A beneficiary designation or change will become effective on the date You execute it. However, the Life Insurance Company will not be liable for any action taken or payment made before they record notice of the change at their Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless You have specified otherwise. The share of any beneficiary who does not survive You or Your Spouse will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if You die while benefits are payable to You, the Life Insurance Company may make direct payment to the first surviving class of the following classes of persons:

1. spouse;
2. child or children;
3. mother or father;
4. sisters or brothers;
5. your estate or the estate of your Spouse.

Recovery of Overpayment

If benefits are overpaid, the Life Insurance Company has the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when You or Your Spouse die, the Life Insurance Company may recover the overpayment from Your or Your Spouse's estate.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss The Life Insurance Company will pay the benefit for any one of the Covered Losses listed in the **Schedule of Benefits,** if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the **Schedule of Benefits**.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

Definitions **Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total Paralysis of both upper and both lower limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Uniplegia means total Paralysis of one upper or one lower limb.

Coma means a profound state of unconsciousness which resulted directly and independently from all other causes from a Covered Accident, and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.

Severance means the complete and permanent separation and dismemberment of the part from the body.

Exclusions The exclusions that apply to this benefit are in the **Common Exclusions** section.

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the **Schedule of Covered Losses** and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

EXPOSURE AND DISAPPEARANCE COVERAGE

Benefits for Accidental Death and Dismemberment, as shown in the **Schedule of Covered Losses**, will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

Exclusions The exclusions that apply to this coverage are in the **Common Exclusions** Section (of this chapter).

ADDITIONAL ACCIDENT BENEFITS

Accidental Death and Dismemberment benefits are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other Accidental Death and Dismemberment benefit payable.

CHILD CARE CENTER BENEFIT

The Life Insurance Company will pay benefits shown in the **Schedule of Benefits** for the care of each surviving Dependent Child in a Child Care Center if death of the covered Employee results directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. coverage for his Dependent Children was in force on the date of the Covered Accident causing his death; and
2. one or more surviving Dependent Children is under Age 13 and:
   a. was enrolled in a Child Care Center on the date of the Covered Accident; or
   b. enrolls in a Child Care Center within 90 days from the date of the Covered Accident.

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each 12 month period that begins after the date of the covered Employee's death. A claim must be submitted to the Life Insurance Company at the end of each 12 month period. A 12 month period begins:

1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in (2b) above, after the covered Employee's death; or
2. on the first of the month following the covered Employee's death, if the Dependent Child was enrolled in a Child Care Center before the covered Employee's death.

Each succeeding 12 month period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

Definitions For purposes of this benefit:
Child Care Center is a facility which:
1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:
1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

Exclusions The exclusions that apply to this benefit are in the **Common Exclusions** Section.

SEATBELT AND AIRBAG BENEFIT

The Life Insurance Company will pay the benefit shown in the **Schedule of Benefits**, subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to the Life Insurance Company.

If such certification or police report is not available or it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, the Life Insurance Company will pay a default benefit shown in the **Schedule of Benefits** to the Covered Person's beneficiary.

Definitions For purposes of this benefit:
Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas.

Automobile means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

Exclusions The exclusions that apply to this benefit are in the **Common Exclusions** Section.

SPECIAL EDUCATION BENEFIT

The Life Insurance Company will pay the benefit, up to the Maximum Benefit shown in the **Schedule of Benefits**, for each qualifying Dependent Child who is insured under the covered Employee's certificate on the date he dies. The Covered Person's death must result, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit is payable under this Policy. This benefit is subject to the conditions and exclusions described below.

A qualifying Dependent Child must:

1. a. be enrolled as a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the covered Employee's Covered Accident; or
   b. be at the 12th grade level on the date of the covered Employee's Covered Accident and then enroll as a full-time student at an accredited school of higher learning within 365 days from the date of the Covered Accident and continue his education as a full-time student.
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian, if the child is a minor at the end of each year for the number of years shown in the **Schedule of Benefits**. The Life Insurance Company must receive proof satisfactory to the Life Insurance Company of the Dependent Child's enrollment and attendance within 31 days of the end of each year.

The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered Employee died, if the surviving Dependent Child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

If no Dependent Child qualifies for Special Education Benefits within 365 days of the covered Employee's death, the Life Insurance Company will pay the default benefit shown in the **Schedule of Benefits** to the covered Employee's beneficiary.

Exclusions The exclusions that apply to this benefit are in the **Common Exclusions** Section.

SPOUSE RETRAINING BENEFIT

The Life Insurance Company will pay expenses incurred, as described below, up to the Maximum Benefit shown in the **Schedule of Benefits,** to enable the covered Employee's Spouse to obtain occupational or educational training needed for employment if the covered Employee dies directly and independently of all other causes from a Covered Accident. A covered Spouse must have been insured under this Policy on the date of the covered Employee's death to be eligible for this benefit. This benefit is subject to the conditions and exclusions described below.

This benefit will be payable if the covered Employee dies within one year of a Covered Accident and is survived by his Spouse who:

1. enrolls, within three years after the covered Employee's death in any accredited school for the purpose of retraining or refreshing skills needed for employment; and
2. incurs expenses payable directly to, or approved and certified by, such school.

Exclusions The exclusions that apply to this benefit are in the **Common Exclusions** Section.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Life Insurance Company. You must complete your claim according to directions provided by the Life Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Plan Administrator.

The Plan Administrator has appointed the Life Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Life Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Life Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Life Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Life Insurance Company may require more time to review your claim if necessary due to

circumstances beyond its control. If this should happen, the Life Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Life Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Life Insurance Company will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Life Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Life Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Life Insurance Company within the review period. The Life Insurance Company's written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.

Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Life Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. **If you do not make this request within that time, you will have waived your right to appeal**.

Once your request has been received by the Life Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Life Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Life Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Life Insurance Company may require more time to review your claim. If this should happen, the Life Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (or 45 days, in the case of any claim for disability benefits).

Once its review is complete, the Life Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.