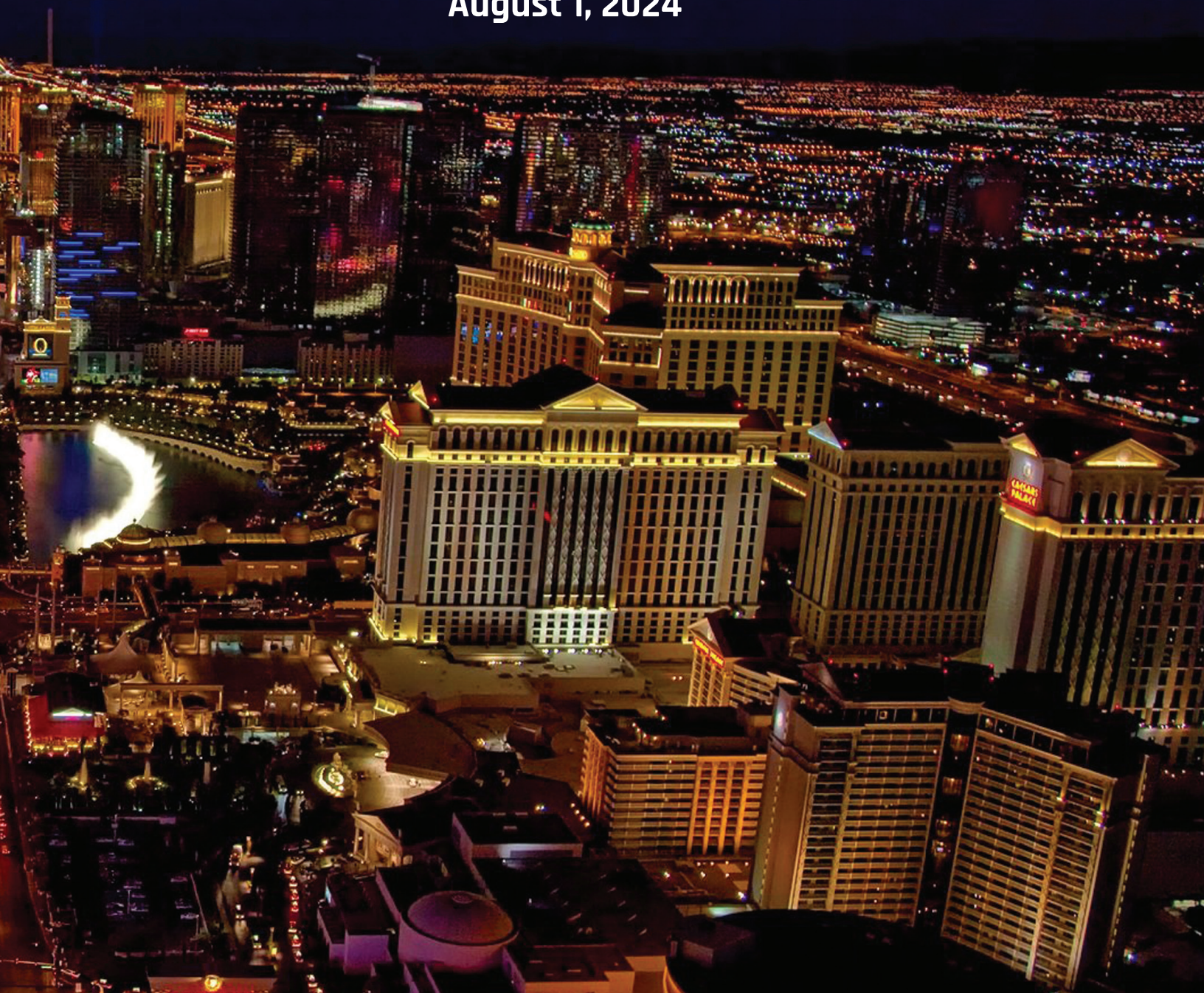
Teamsters Local 631 Security Fund

Plan Document and Summary Plan Description

August 1, 2024



TEAMSTERS LOCAL 631

SECURITY FUND

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

August 1, 2024

A Letter From the Board of Trustees

Dear Participants:

The Trustees of the Teamsters Local 631 Security Fund ("Plan") are pleased to present you with this new Plan booklet describing the Plan's benefits, including medical, outpatient, Prescription Drug benefits, dental, vision, life insurance, and Accidental Death and Dismemberment ("AD&D"). This booklet contains important information about the benefits available to you and your family. Please read this booklet carefully and keep it where you can find it in the future.

In this book, you will find information about who is covered by the Plan and what benefits are available. This Plan Book, also referred to as the Plan document, the Summary Plan Description or "SPD", supersedes and replaces all previous Plan materials. The Plan offers two medical benefit and Prescription Drug coverage options - (1) a fee-for-service ("Indemnity") benefit option and (2) an exclusive provider organization ("EPO") benefit option. In addition, the Plan offers dental and vision benefits.

All Active Employees may enroll themselves and their dependents in either benefit option. Retirees and their Dependents may enroll in the EPO only.

The Trustees want the Plan to continue well into the future. However, Plan benefits are not guaranteed to always be available for you and your family (the benefits are not "vested"). Events may happen in the future that force the Trustees to change the benefits or even stop providing benefits altogether. Therefore, the Trustees have full authority to change, reduce or end any Plan benefits at any time they deem necessary. If the Trustees change the Plan, you will be informed of any changes by first class mail.

All questions about the Plan should be made to the Administrative Office for the Plan. The address and telephone number for the Administrative Office are in the Quick Guide to Important Contacts. The only people who are authorized to give you official answers to your questions about the Plan are the Trustees or the Administrative Office. Only answers that are in writing are official and may be relied on. No employer, employer association or labor organization, or any of their employees, can give you official answers to your questions about the Plan.

The Trustees believe that the Plan fully complies with the Employee Retirement Income Security Act of 1974 ("ERISA") and other applicable laws, regulations and amendments. Any ambiguities, omissions or oversights will be resolved in favor of the laws and regulations.

If you (and/or your Dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your Prescription Drug coverage. Please see page 72 for more details.

Be a Wise Consumer . . . It Will Save You Money

We all know that obtaining health care benefits has become more complicated for both the Plan and for you. This is because health care benefits have become more expensive than ever before, and there is a limited supply of money to pay for benefits. Like your family, the Plan has a budget and needs to spend wisely the limited amount of health care money it has available.

By understanding your health care benefits and using them wisely, you will get the most benefits with the least cost to you. There are two (2) easy ways to reduce your health costs when receiving benefits through

the Plan. First, use Exclusive Provider Organization ("EPO") or Preferred Provider Organization providers ("PPO"). As you can see from the descriptions of benefits in this Plan booklet, you pay a lower Copayment or Coinsurance for many medical services when you use PPO Providers. If you use Non-EPO or Non-PPO Providers, you will pay more. You are responsible for knowing whether your provider is within the network or not.

The second way you can reduce your medical costs is by being a wise consumer. Be sure to ask questions of your health care providers and demand proper answers. Don't rely on your Doctors or health care providers to know your benefit plan. You have to take control of your benefit decisions and make sure that you use your benefits wisely. For example, if your PPO Physician refers you to another Physician or laboratory, be sure that YOU confirm that the other Physician or laboratory is on the PPO or EPO list. Don't rely on your Doctor to do so.

Some services require Prior Authorization (or "Preauthorization"). You are responsible for confirming that your Physician or other provider obtains Prior Authorization for certain services described in this Plan booklet. Don't rely on your Doctor or other health care provider to obtain Prior Authorization. You must check on it yourself. If you do not obtain Prior Authorization for the services listed, the Plan will pay a much lower amount and you will pay a much higher amount. Your health care is your responsibility.

PRIOR AUTHORIZATION FOR ANY HEALTH CARE SERVICE OR PROCEDURE MEANS ONLY THAT THE PROPOSED SERVICES OR PROCEDURE IS MEDICALLY NECESSARY AND APPROPRIATE FOR THE DIAGNOSIS GIVEN. PRIOR AUTHORIZATION DOES NOT MEAN THAT ELIGIBILITY, PAYMENT OR BENEFITS ARE GUARANTEED. PAYMENT FOR HEALTH CARE SERVICE OR PROCEDURE WILL BE DETERMINED ON THE BASIS OF THE PLAN OR BENEFITS IN EFFECT AT THE TIME THE SERVICE OR PROCEDURES ARE PERFORMED, REGARDLESS OF ANY PRIOR AUTHORIZATION.

If you would like further information or assistance, please call or write the Administrative Office listed in the Quick Guide to Important Contacts.

ESTE FOLLETO CONTIENE UN RESUMEN EN INGLÉS DE SU PLAN DE DERECHOS Y BENEFICIOS BAJO EL TEAMSTERS LOCAL 631 SECURITY FUND. SI SE LE DIFICULTA ENTENDER CUALQUIER PARTE DE ESTE FOLLETO, PÓNGASE EN CONTACTO CON BENESYS ADMINISTRATORS EL ADMINISTRADOR DEL PLAN, AL 8311 W. SUNSET ROAD, SUITE 250, LAS VEGAS, NV 89113. LAS HORAS DE OFICINA SON DE LUNES A VIERNES DE 8 A.M. A 4:00 P.M. TAMBIÉN PUEDE PONERSE EN CONTACTO CON LA OFICINA DEL ADMINISTRADOR LLAMANDO AL (702) 415-2185 / (877) 304-6702.

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QUICK GUIDE TO IMPORTANT CONTACTS

Administrative Office for the Plan BeneSys Administrators 8311 W. Sunset Road, Suite 250 Las Vegas, NV 89113 (702) 415-2185 1-877-304-6702 www.teamsters631benefits.org	***Prior Authorization - Utilization Review Organization*** **For Medical Benefits:** Nevada Health Solutions P.O. Box 61440 Las Vegas, NV 89160 (702) 216-1653 (855) 392-0778 Fax (702) 691-5614 https://nevadahealthsolutions.org **For Mental Health/Substance Use Disorder Benefits:** Human Behavior Institute Clinical Services (HBI) 2740 South Jones Blvd., Las Vegas, NV 89146 Phone: 800.441.4483/702.248.8866 Ext. 811 Fax: 702.248.0079 For after-hours & 24/7 Mobile Crisis Team/Case Management 800.441.4483 /702.248.8866 option 7
Medical Preferred Provider Network (PPO and EPO Providers) Anthem Blue Cross Blue Shield P.O. Box 5747 Denver, CO 80217 1-800-234-0111 www.anthem.com	***Life and AD&D Benefits*** LINCOLN FINANCIAL GROUP P.O. Box 21008 Greensboro, North Carolina 27420 (800) 444-2363 Fax (336) 335-2054 www.lfg.com
Member Assistance Program (MAP) Administrator for Mental Health and Substance Use Disorder Benefits Anthem Blue Cross Blue Shield P.O. Box 5747 Denver, CO 80217 1-800-234-0111 www.anthem.com	***Prescription Drug Benefit Manager*** OptumRx PO Box 650334 Dallas, TX 75265-0334 https://optumrx.com (800) 299-1358 https://specialty.optumrx.com (877) 838-2907

Vision Benefits DAVIS VISION (800) 999-5431 www.davisvision.com Enhanced eyewear benefits available at Visionworks locations. 3962 Blue Diamond Rd. Las Vegas, NV 89139 (702) 260-4127 3460 S. Maryland Parkway Las Vegas, NV 89169 (702) 731-3968 4300 Meadows Mall, Space 104 Las Vegas, NV 89107 (702) 822-6848 681 Mall Ring Circle Henderson, NV 89014 (702) 433-4727	***Dental Network and Claims Administration*** NEVADA DENTAL BENEFITS (NDB) (702) 478-2014 or (866) 998-3944 Physical Address: 7872 West Sahara Avenue Las Vegas, NV 89117 Claims Address: P.O. Box 271000 Las Vegas, NV 89127 www.nevadadentalbenefits.com
Transplant Provider INTERLINK 4660 N.E. Belknap Ct., Ste. 209 Hillsboro, OR 91724 (800) 599-9119	***Mobile Health Services*** DISPATCH HEALTH (720) 588-9686 www.dispatchhealth.com
Teamsters 631 Medical Centers 7973 Peak Drive Las Vegas, Nevada 89128 (702) 850-3003	2510 Wigwam Pkwy, Suite 109 Henderson, Nevada 89074 (702) 268-9001

IMPORTANT NOTE: None of these entities can determine whether benefits are covered by the Plan, even if the treatment is "approved" or "Preauthorized" as being Medically Necessary and appropriate. Only the terms of the Plan and the Trustees can determine whether benefits are covered.

QUICK GUIDE TO BENEFITS - INDEMNITY MEDICAL PLAN

Partial Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS Enrolled in Indemnity Medical (PPO) Plan Prior Authorization is required for a variety of services as described in Part 6.G.		
SUMMARY OF BENEFITS	**In-Network**	**Out of Network**
Deductibles	No Calendar Year Deductible, $100 Deductible per inpatient admission	$500 Calendar Year Deductible per person, $1,500 per family of three or more. $600 Deductible per inpatient admission
Coinsurance Maximum	$2,500 coinsurance for Allowable Expenses per person, exclusive of Deductibles and Copayments; $5,000 per family of three or more.	No maximum
Out-of-Pocket Maximum for Essential Health Benefits	The Annual Out-of-Pocket Maximum for Essential Health Benefits is $6,600 per person, $13,200 per family. This Annual Out-of-Pocket Maximum includes all Copayments, Coinsurance and Deductibles.	For services provided by Non-Network Providers, there is no Annual Out-of-Pocket Maximum. Use PPO-Providers when possible for non-Emergency Services in order to minimize your potential out-of-pocket expenses. Amounts paid for Emergency Services, air ambulance services, and services performed by a Non-Network Provider in certain participating facilities shall be credited towards the annual limit for PPO medical benefits.
Preauthorization Requirement	Inpatient hospitalizations, Residential Treatment Programs, Skilled Nursing Facility and Inpatient Rehabilitation in a skilled care unit or LTAC and certain other procedures must be Preauthorized, or benefits may be denied or reduced to payment of 50% of Allowable Expenses. (Refer to Part 6.G. of the Plan and the Quick Guide to Important Contacts for additional information and phone numbers. Prior Authorization for Medical Services, Behavioral Health, and Mental Health or Substance Use Disorder services is provided by the Utilization Review Organization.	
	Coinsurance / Copayments / Limits	
Inpatient Hospital Facility Services	$100 Deductible per admission; 80% of Allowable Expenses	$600 Deductible per admission; 50% of Allowable Expenses (but if an emergency admission, then $100 Deductible per admission; 80% of Allowable Expenses)

Partial Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS Enrolled in Indemnity Medical (PPO) Plan **Prior Authorization is required for a variety of services as described in Part 6.G.**		
SUMMARY OF BENEFITS	**In-Network**	**Out of Network**
Outpatient Surgical Facility Services (Free-standing facility)	$150 Copay per treatment	50% of Allowable Expenses
Outpatient Surgical Facility Services (Hospital-based facility)	$250 Copay per treatment	50% of Allowable Expenses
Skilled Nursing Facility Services (up to 60 days per Calendar Year)	$100 Deductible per admission; 80% of Allowable Expenses	Not Covered
Medical Services Primary Care Physician Office/Hospital Specialist/Consultant Office/Hospital Manual Manipulation (Maximum Benefit of 20 visits per Calendar Year) *Only one copay will be charged per physician per day and one copay per specialist per day even when ancillary services are provided in conjunction with the physician or specialist visit – OB/GYN providers are treated the same as primary care providers for purposes of determining copay amounts.*	 $15 Copay per visit $25 Copay per visit $15 Copay per visit	 50% of Allowable Expenses 50% of Allowable Expenses 50% of Allowable Expenses
Family Planning Vasectomy	$0 Copay	50% of Allowable Expenses
TMJ Treatment (Maximum Benefit of $2,500 per Calendar Year; $4,000 maximum lifetime benefit)	50% of Allowable Expenses	50% Allowable Expenses
Inpatient & Outpatient Surgical Services Attending Physician/Surgeon/Specialist Assistant Surgeon Anesthesia Services Surgery Performed in Physician Office (including OB/GYN) Attending Physician Specialist	 $25 Copay per procedure $25 Copay per procedure $50 Copay per procedure $15 Copay per procedure $25 Copay per procedure	 50% of Allowable Expenses 50% of Allowable Expenses 50% of Allowable Expenses 50% of Allowable Expenses 50% of Allowable Expenses
Laboratory Services	100% of Allowable Expenses	50% of Allowable Expenses
Routine Radiological and Non-Radiological Diagnostic Imaging/Testing (other than services required under Health Care Reform)	$20 Copay	50% of Allowable Expenses

Partial Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS Enrolled in Indemnity Medical (PPO) Plan **Prior Authorization is required for a variety of services as described in Part 6.G.**		
SUMMARY OF BENEFITS	**In-Network**	**Out of Network**
Other Diagnostic and Therapeutic Services		
Chemotherapy	$25 Copay	50% of Allowable Expenses
Therapeutic Radiology	$25 Copay	50% of Allowable Expenses
Allergy Testing & serum injections	$25 Copay per treatment	50% of Allowable Expenses
Amniocentesis	$20 Copay Expenses	50% of Allowable Expenses
Other Complex Diagnostic and Therapeutic Services (CT Scan, MRI, etc.)	$50 Copay per procedure at free-standing facility/$150 Copay per procedure at hospital-based facility	50% of Allowable Expenses
Medical Supplies	100% of Allowable Expenses	50% of Allowable Expenses
Prosthetics and Orthotic Devices Integral Part of a Brace	$50 Copay	50% of Allowable Expenses
Non-Brace Orthotics	100% of Allowable Expenses up to $500 maximum; 10% of Allowable Expenses above $500	50% of Allowable Expenses up to $1,000; 10% of Allowable Expenses above $1,000
Durable Medical Equipment (one-device limit per device type per three-year period; no limit on number of different items)	$50 Copay	50% of Allowable Expenses
Second/Third Specialist Opinion	$20 Copay per visit	50% of Allowable Expenses
Emergency Services	$250 Copay for facility and $25 Copay for Physician services per visit	$250 Copay for facility and $25 Copay for Physician services per visit
	For non-Emergency Services received in an emergency room, the Maximum Benefit is $75	
Urgent Care Centers	$50 Copay per visit	50% of Allowable Expenses
Ambulance Services	$50 Copay per trip (ground)	$50 Copay per trip (ground)
Air Ambulance	$50 Copay per trip	$50 Copay per trip
Home Health Care Services	$0 Copay	50% of Allowable Expenses
Hospice	80% of Allowable Expenses	$600 Deductible per admission; 50% of Allowable Expenses

Partial Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS Enrolled in Indemnity Medical (PPO) Plan **Prior Authorization is required for a variety of services as described in Part 6.G.**		
SUMMARY OF BENEFITS	**In-Network**	**Out of Network**
Short Term Physical, Occupational, and Speech Therapy Services Outpatient Inpatient	\$15 Copay per therapy session 80% of Allowable Expenses \$100 Deductible per admission, waived if admitted from acute facility	50% of Allowable Expenses Not Covered.
	All short-term Physical, Occupational, and Speech Therapy benefits have a combined inpatient and outpatient lifetime Maximum Benefit of 90 visits per Calendar Year. *Prior authorization is required after 60 visits*	

Partial Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS Enrolled in Indemnity Medical (PPO) Plan Prior Authorization is required for a variety of services as described in Part 6.G.		
SUMMARY OF BENEFITS	**In-Network**	**Out of Network**
Prescription Drugs (Prior Authorization and case management guidelines may be required)		
Retail Pharmacy Program for 30 day supply	$0 Copay for generic drugs $40 Copay for preferred brand drugs $80 Copay for non-preferred brand drugs	50% of Allowable Expenses
Retail Pharmacy (Network Provider only)* for 60-day supply	$0 Copay for generic drugs $80 Copay for preferred brand drugs $160 Copay for non-preferred brand drugs	Not applicable
Retail Pharmacy (Network Provider only)* for 90-day supply	$0 Copay for generic drugs $120 Copay for preferred brand drugs $240 Copay for non-preferred brand drugs	Not applicable
Mail Order Program with maximum 90 day supply limit	$0 Copay for generic drugs $80 Copay for preferred brand drugs $160 Copay for non-preferred brand drugs	Not covered
Specialty Drugs (covered under Prescription Drug plan only) with maximum 30 day supply limit * Available only at participating CVS Pharmacies	20% coinsurance up to $200 per prescription	Not covered

Partial Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS Enrolled in Indemnity Medical (PPO) Plan **Prior Authorization is required for a variety of services as described in Part 6.G.**		
SUMMARY OF BENEFITS	**In-Network**	**Out of Network**
Preventive Care		
Services rated "A" or "B" by the U.S. Preventive Services Task Force	100% of Allowable Expenses	50% of Allowable Expenses; $500 Deductible
Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (***No benefits are provided for immunizations or vaccines required or recommended for foreign travel***).	100% of Allowable Expenses	50% of Allowable Expenses; $500 Deductible
Preventive care and screenings for women and children as recommended by the Health Resources and Services Administration The current list of Preventive Care Benefits, includes but is not limited to the following services: Mammograms and other cancer screening; abdominal ultrasounds for men 65-75 who have ever smoked; bone screens for osteoporosis; pap smears; HPV testing; colonoscopy / sigmoidoscopy; and blood tests for syphilis, gonorrhea, HIV, cholesterol/lipid panels and blood sugar. **NOTE**: Non-Network Providers are covered at 50% of Allowable Expenses and subject to the Non-Network Provider $500 Calendar Year Deductible. Preventive Care Benefits provided by a Non-PPO Provider will be 100% covered only if the particular item or service provided by the Non-PPO Provider is not available from a PPO Provider.	100% of Allowable Expenses	50% of Allowable Expenses; $500 Deductible
Hearing Benefit		
Primary Physician/Office visit	$15 Copay per visit	50% of Allowable Expenses
Specialist/otological evaluation & testing	$25 Copay per visit	50% of Allowable Expenses
Hearing aid (Maximum Benefit of $500 per ear per 3 years)	100% of Allowable Expenses	50% of Allowable Expenses; no Deductible

Partial Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS Enrolled in Indemnity Medical (PPO) Plan **Prior Authorization is required for a variety of services as described in Part 6.G.**		
SUMMARY OF BENEFITS	**In-Network**	**Out of Network**
Behavioral Health Benefits		
MAP Counseling	24-hour crisis intervention; 6 free counseling sessions per issue per year per family; group treatment available for adolescents, anxiety, anger management, chemical dependency, problem gambling, anxiety	Not Covered
Bereavement Services	$15 Copay per session	50% of Allowable Expenses
Outpatient Counseling	$15 Copay per session	50% of Allowable Expenses
Acute Hospital	$100 Deductible per admission; 80% of Allowable Expenses after Deductible met	$600 Deductible per admission; 50% of Allowable Expenses after Deductible met (but if an emergency admission, then $100 Deductible per admission; 80% of Allowable Expenses after PPO Deductible is met)
Residential Treatment Programs, Group Homes, Halfway House	80% of Allowable Expenses without a Deductible	Not Covered
Day Treatment	$15 Copay per day	50% of Allowable Expenses
Emergency Services	$250 Copay for facility and $25 Copay for Physician services per visit	$250 Copay for facility and $25 Copay for Physician services per visit
Substance Use Disorder Treatment	Substance use disorder benefits have the same Copays and Coinsurance as Behavioral Health Services	Substance use disorder benefits have the same Copays and Coinsurance as Behavioral Health Services
Outpatient Dialysis	80% of Allowable Expenses	50% of Allowable Expenses
Autism Treatment, including Applied Behavioral Analysis (ABA) Therapy (limited to $72,000 per year for children up to age 18, or 22 if still enrolled in high school) *Prior Authorization is required.*	$25 Copay per visit	Not Covered

Partial Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS Enrolled in Indemnity Medical (PPO) Plan **Prior Authorization is required for a variety of services as described in Part 6.G.**		
SUMMARY OF BENEFITS	**In-Network**	**Out of Network**
Dispatch Health – Mobile Visit *Prior authorization is required.*	$50 Copay per visit	Not applicable
Hospitalists		
Designated Hospitalist	No charge	No charge if receiving services in a participating facility; Not covered if in a nonparticipating facility
Non-Designated Hospitalist *Only one copay will be charged per physician per day and one copay per specialist per day even when ancillary services are provided in conjunction with the physician or specialist visit – OB/GYN providers are treated the same as primary care providers for purposes of determining copay amounts.*	Not covered	Not covered

QUICK GUIDE TO BENEFITS – EPO PLAN – ACTIVE EMPLOYEE AND PRE-MEDICARE RETIREE COVERAGE

Except for Emergency Services, there are no EPO benefits provided for Non-EPO Provider services.

Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND PRE-MEDICARE RETIREES AND THEIR DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
Deductibles	None
Out-of-Pocket Maximum	The Annual Out-of-Pocket Maximum is $6,250 per person, $12,500 per family.
Preauthorization Requirement	Inpatient hospitalization and certain procedures must be Preauthorized or benefits will not be covered.
	Benefits / Copayments
Inpatient Hospital Facility Services (Limit three days per admission)	$300 Copay per day up to a maximum of $900 per admission
Inpatient Surgical Services Attending Physician/Surgeon/Specialist Assistant Surgeon Anesthesia Services	 $150 Copay per procedure No charge $150 Copay per surgery
Outpatient Surgical Services (Free-standing facility) Outpatient Facility Attending Physician/Surgeon/ Anesthesia Surgery Performed in Physician Office	 $150 Copay per procedure $150 Copay per procedure $150 Copay per procedure $75 Copay per visit, $50 Anesthesia, plus $25 Copay for office visit
Outpatient Surgical Services (Hospital-based facility) Outpatient Facility Attending Physician/Surgeon Anesthesia	 $250 Copay per procedure $150 Copay per procedure $150 Copay per procedure
Skilled Nursing Facility Services	$400 Copay per admission, limited to 100 days per member per Calendar Year
Medical Services Attending Physician Office/Hospital Specialist/Consultant Office/Hospital House Calls Manual Manipulation – Maximum 20 visits per calendar year	 $25 Copay/office, no charge for inpatient $50 Copay, no charge for inpatient $35 Copay per visit $25 Copay per visit
Podiatry	$50 Copay per visit
Pregnancy – Delivery & Newborn Services Delivery Hospital Services (Limited to three days per admission) Anesthesia	$300 per day up to a maximum of $900 per admission

Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND PRE-MEDICARE RETIREES AND THEIR DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
Midwife	No Charge
Delivery Physician Services	No Charge
Newborn Services	$150 per delivery
Laboratory Services	$15 per visit (no more than one Copay per day)
Routine Radiology	$25 Copay
Other Diagnostic and Therapeutic Services	
Chemotherapy	$50 Copay per day
Therapeutic Radiology	$50 Copay per day
Dialysis	No charge
Infusion Therapy	$50 Copay per visit
Allergy Testing & Serum Injections	$50 Copay per visit
Other Complex Diagnostic and Therapeutic Services (CT Scan, MRI, etc.)	$100 Copay per procedure at free-standing facility/$150 Copay per procedure at hospital-based facility
Prosthetics and Orthotic Devices	$750 Copay per device, $10,000 lifetime max benefit, including repairs
Durable Medical Equipment (one device limit per device type three year period; no limit on number of different items)	No charge
Emergency Services **Benefits are the same for Emergency Services provided by Non-EPO Providers.*	$250 Copay for emergency room (waived if admitted), and No charge for emergency room physician
Emergency Services received for nonemergencies	Not covered
Urgent Care	$50 Copay
Ambulance Services	
Air ambulance	$250 Copay per trip
Ground Ambulance	$250 Copay per trip
**Benefits are the same for Ambulance Services provided by Non-EPO Providers.*	
Home Health Care Services	No charge
Short Term Physical, Occupational and Speech Therapy Services	
Outpatient	$25 Copay per visit, up to the combined inpatient and outpatient lifetime Maximum Benefit of 90 visits per member per Calendar Year
Inpatient	$25 Copay per visit, after $400 Copay per admission, limited to 90 visits per member per Calendar Year *Prior authorization is required after 60 visits*

Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND PRE-MEDICARE RETIREES AND THEIR DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
Prescription Drugs	
Retail Pharmacy (Network Provider only) for 30-day supply	$0 Copay for generic drugs, $40 Copay for preferred drugs, $80 Copay for non-preferred brand drugs
Retail Pharmacy (Network Provider only) for 60-day supply*	$0 Copay for generic drugs $80 Copay for preferred brand drugs $160 Copay for non-preferred brand drugs
Retail Pharmacy (Network Provider only) for 90-day supply*	$0 Copay for generic drugs $120 Copay for preferred brand drugs $240 Copay for non-preferred brand drugs
Mail Order Program with maximum 90-day supply limit*	$0 Copay for generic drugs, $80 Copay for preferred brand drugs, $160 for non-preferred brand drugs
Specialty Drugs covered under Prescription Drug plan only) with maximum 30-day supply limit * Available only at participating CVS Pharmacies.	20% coinsurance up to $200 per prescription
Preventive Care	
Services rated “A” or “B” by the U.S. Preventive Services Task Force	100% of Allowable Expenses
Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (***No benefits are provided for immunizations or vaccines required or recommended for foreign travel***).	100% of Allowable Expenses
Preventive care and screenings for women and children as recommended by the Health Resources and Services Administration The current list of Preventive Care Benefits, includes but is not limited to the following services: Mammograms and other cancer screening;	100% of Allowable Expenses

Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND PRE-MEDICARE RETIREES AND THEIR DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
abdominal ultrasounds for men 65-75 who have ever smoked; bone screens for osteoporosis; pap smears; HPV testing; colonoscopy / sigmoidoscopy; and blood tests for syphilis, gonorrhea, HIV, cholesterol/lipid panels and blood sugar. *Preventive Care Benefits provided by a Non-EPO Provider will be 100% covered only if the particular item or service provided by the Non-EPO Provider is not available from a EPO Provider.*	
Hearing Benefit	
Primary Physician/Office visit	$25 Copay
Specialist/Otological Evaluation and Testing	$50 Copay
Hearing aid	$100 Copay or 50% of Allowable Expenses, whichever is less, subject to $5,000 Maximum Benefit per person per every 3 Calendar Years, repairs/replacement limited to once every 3 years
Acupuncture	Not covered.
Bariatric Surgery Services	
Ambulatory Surgery Center Services	$1,500 Copay per surgery
Inpatient Hospital Services	$1,500 Copay per surgery
Outpatient Hospital Services	$1,500 Copay per surgery
Professional Physician Services	$25 Copay
Diabetes Care	
Equipment	$20 Copay per device, except $100 Copay per insulin pump
Self-management Training	$25 Copay
Insulin & Testing Supplies	See Prescription Drug benefits
Family Planning	
Abortion Services	Not covered
Vasectomy	$0 Copay
Hospice Care	
Outpatient (in-home care)	No Charge
Inpatient care	No Charge
Behavioral Health Benefits	
MAP Counseling	24-hour crisis intervention; 6 free counseling sessions per issue per year per family; group treatment available for adolescents, anxiety, anger management, chemical dependency, problem gambling, anxiety
Outpatient Counseling	$25 Copay per visit
Acute Hospital or Partial Hospitalization	$300 Copay per day up to a maximum of $900 per admission

Summary of Medical Benefits for ALL ACTIVE EMPLOYEES AND PRE-MEDICARE RETIREES AND THEIR DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
Intensive Outpatient Program Office Based Opioid Treatment Emergency Services *Substance Use Disorder Treatment benefits have the same Copays as Behavioral Health Services*	$25 Copay per visit $25 Copay per visit $250 Copay for emergency***Error! Bookmark not defined.*** room (waived if admitted), and No charge for emergency room physician
Autism Treatment, including Applied Behavioral Analysis (ABA) Therapy Office visit In-Home visit (limited to 250 visits per Calendar Year) (limited to $72,000 per year for children up to age 18, or 22 if still enrolled in high school) Prior Authorization is required.	 $25 Copay per visit $25 Copay per visit
Dispatch Health – Mobile Visit Prior authorization is required.	$50 Copay per visit
Hospitalists Designated Hospitalists Non-Designated Hospitalists	 No charge Not covered

QUICK GUIDE TO BENEFITS - EPO PLAN –MEDICARE ELIGIBLE RETIREE COVERAGE

Except for Emergency Services, there are no EPO benefits provided for Non-EPO Provider services.

Summary of Medical Benefits for MEDICARE ELIGIBLE RETIREES AND THEIR MEDICARE ELIGIBLE DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
Deductibles	None
Out-of-Pocket Maximum	The Annual Out-of-Pocket Maximum is $2,500 per person excluding prescription drugs; there is no out-of-pocket maximum for prescription drugs
Preauthorization Requirement	Inpatient hospitalization and certain procedures must be Preauthorized or benefits will not be covered.
	Benefits / Copayments
Inpatient Hospital Facility Services	No Charge
Inpatient Surgical Services Attending Physician/Surgeon/Specialist Assistant Surgeon Anesthesia Services	 No Charge No Charge No Charge
Outpatient Surgical Services (Free-standing facility or Hospital-based facility) Outpatient Facility Attending Physician/Surgeon/ Anesthesia Surgery Performed in Physician Office	 No Charge No Charge No Charge No Charge
Skilled Nursing Facility Services	$0 Copay for days 1 to 20; $25 per day for days 21 to 100, limited to 100 days per member per Calendar Year
Medical Services Attending Physician Office/Hospital Specialist/Consultant Office/Hospital House Calls Manual Manipulation	 No Charge No Charge No Charge No Charge
Podiatry	No Charge; limited to 4 visit per year
Pregnancy – Delivery & Newborn Services Delivery Hospital Services Anesthesia Midwife Delivery Physician Services Newborn Services	 No Charge No Charge No Charge No Charge No Charge
Laboratory Services	No Charge
Routine Radiology	No Charge

Summary of Medical Benefits for MEDICARE ELIGIBLE RETIREES AND THEIR MEDICARE ELIGIBLE DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
Other Diagnostic and Therapeutic Services	
Chemotherapy	No Charge
Therapeutic Radiology	$25 Copay per day
Dialysis	No Charge
Infusion Therapy	No Charge
Allergy Testing & Serum Injections	No Charge
Other Complex Diagnostic and Therapeutic Services (CT Scan, MRI, etc.)	$100 Copay per procedure
Prosthetics and Orthotic Devices	20% Coinsurance
Durable Medical Equipment) (one device limit per device type three year period; no limit on number of different items)	20% Coinsurance
Emergency Services **Benefits are the same for Emergency Services provided by Non-EPO Providers.* Emergency Services received for nonemergencies	$25 Copay for emergency room (waived if admitted), and No charge for emergency room physician Not covered
Urgent Care	Network provider - $15 Copay Non-Network provider - $25 Copay
Ambulance Services	
Air ambulance	No Charge
Ground Ambulance	No Charge
**Benefits are the same for Ambulance Services provided by Non-EPO Providers.*	
Home Health Care Services	No Charge
Short Term Physical, Occupational and Speech Therapy Services	
Outpatient	$15 Copay per visit
Inpatient	$15 Copay per visit

Summary of Medical Benefits for MEDICARE ELIGIBLE RETIREES AND THEIR MEDICARE ELIGIBLE DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
Prescription Drugs	
Retail Pharmacy (Network Provider only) for 30-day supply*	$0 Copay for generic drugs $35 Copay for preferred brand drugs $60 for non-preferred brand drugs
Retail Pharmacy (Network Provider only) for 60-day supply*	$0 Copay for generic drugs $70 Copay for preferred brand drugs $120 Copay for non-preferred brand drugs
Retail Pharmacy (Network Provider only) for 90-day supply*	$0 Copay for generic drugs $105 Copay for preferred brand drugs $180 Copay for non-preferred brand drugs
Mail Order Program with maximum 90-day supply limit*	$0 Copay for preferred generic, $70 Copay for preferred brand, $120 for preferred brand drugs
Specialty Drugs (covered under Prescription Drug plan only) with maximum 30-day supply limit	20% coinsurance up to $200 per prescription
* Available only at participating CVS Pharmacies.	
Preventive Care	
Services rated “A” or “B” by the U.S. Preventive Services Task Force	100% of Allowable Expenses
Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (No benefits are provided for immunizations or vaccines required or recommended for foreign travel).	100% of Allowable Expenses
Preventive care and screenings for women and children as recommended by the Health Resources and Services Administration	100% of Allowable Expenses

Summary of Medical Benefits for MEDICARE ELIGIBLE RETIREES AND THEIR MEDICARE ELIGIBLE DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
The current list of Preventive Care Benefits, includes but is not limited to the following services: Mammograms and other cancer screening; abdominal ultrasounds for men 65-75 who have ever smoked; bone screens for osteoporosis; pap smears; HPV testing; colonoscopy / sigmoidoscopy; and blood tests for syphilis, gonorrhea, HIV, cholesterol/lipid panels and blood sugar. *Preventive Care Benefits provided by a Non-EPO Provider will be 100% covered only if the particular item or service provided by the Non-EPO Provider is not available from a EPO Provider.*	
Hearing Benefit	
Primary Physician/Office visit	No Charge
Specialist/Otological Evaluation and Testing	No Charge
Hearing aid	$330 copay for over the ear hearing aid $380 copay for open fit in the ear canal heating aid
Acupuncture	Not covered.
Bariatric Surgery Services	
Ambulatory Surgery Center Services	No Charge
Inpatient Hospital Services	No Charge
Outpatient Hospital Services	No Charge
Professional Physician Services	No Charge
Diabetes Care	
Equipment	No Charge
Self-management Training	No Charge
Insulin & Testing Supplies	See Prescription Drug benefits; no charge for testing supplies
Family Planning	
Abortion Services	Not covered
Vasectomy	No Charge
Hospice Care	
Outpatient (in-home care)	No Charge
Inpatient care	No Charge

Summary of Medical Benefits for MEDICARE ELIGIBLE RETIREES AND THEIR MEDICARE ELIGIBLE DEPENDENTS Enrolled in EPO Option Prior Authorization is required for a variety of services as described in Part 6.G.	
SUMMARY OF BENEFITS	**EPO Plan**
Behavioral Health Benefits MAP Counseling	24-hour crisis intervention; 6 free counseling sessions per issue per year per family; group treatment available for adolescents, anxiety, anger management, chemical dependency, problem gambling, anxiety
Outpatient Counseling	$15 Copay per visit
Acute Hospital or Partial Hospitalization	No Charge
Intensive Outpatient Program	$15 Copay per visit
Office Based Opioid Treatment	$15 Copay per visit
Emergency Services	$25 Copay for emergency room (waived if admitted), and No charge for emergency room physician
Substance Use Disorder Treatment benefits have the same Copays as Behavioral Health Services	
Autism Treatment, including Applied Behavioral Analysis (ABA) Therapy	
Office visit	Not covered
In-Home visit (limited to 250 visits per Calendar Year) (limited to $72,000 per year for children up to age 18, or 22 if still enrolled in high school) *Prior Authorization is required.*	Not Covered
Dispatch Health – Mobile Visit *Prior authorization is required.*	$20 Copay per visit
Hospitalists	
Designated Hospitalists	No charge
Non-Designated Hospitalists	Not covered

PART 1. ELIGIBILITY

You are eligible for benefits under the Plan if you are a regular Active Employee of a Contributing Employer who is party to a Collective Bargaining Agreement under which your Contributing Employer is making the required Contributions to the Teamsters Local 631 Security Fund for Southern Nevada on your behalf for the purpose of providing you with health and welfare benefits. (For nonbargaining employee eligibility, please refer to the specific applicable agreement.)

A. Active Employees.

1. Eligibility. You are eligible for health and welfare benefit coverage if your Contributing Employer is required to make Contributions to the Plan on your behalf as an Active Employee as required by Collective Bargaining Agreement or other written agreement.

2. When You Become Eligible. If you are an Active Employee, you and your Eligible Dependents will first become covered under the Plan on the first day of the second calendar month after your Contributing Employer has paid an amount equal to two (2) consecutive full months' Contributions into the Plan for you. A full month's Contributions is based on the amount of money or hours determined and defined by the Trustees from time to time. Of those two (2) full months' Contributions, the Contribution for one (1) month will be held in the Plan as a reserve, and the remainder shall be used to provide coverage in the Plan.

   Example: You are employed by a Contributing Employer in January. You work enough hours in January and February to have two (2) full months' Contributions made on your behalf. You are eligible for coverage beginning April 1 (March is a reporting "lag" month).

3. Breaks in Covered Employment and Lapse of Contributions. In relation to achieving initial eligibility, if the full required Contribution for each month is not received for two (2) consecutive months as discussed above, any Contribution amounts less than the full required Contributions are forfeited and cancelled. If you accumulate more hours or dollars than needed during the two (2) consecutive months that give you initial eligibility, you may carry them over to your Bank for future eligibility. See Part 3 for more information.

4. Exception for Convention Industry. For certain Employees working in the Convention Industry, these rules do not apply. Convention Industry workers must work at least 100 hours per month in order to be eligible under the Plan.

B. Retirees. See Part 12 for Retiree coverage.

C. **Dependents**.

1. Eligible Dependents. Eligible Dependents of eligible Active Employees include—

   a. Your legal spouse and each of your children until the last day of the month in which the child reaches age 26, whether married or unmarried.

b. Dependent Eligibility Rules:

(1) Children include natural children, stepchildren, legally adopted children, children placed with you for adoption, and children under court appointed legal guardianship. An Active Employee's foster child, son-in-law, daughter-in-law, or domestic partner are not eligible as Dependents.

(2) Adopted children. Coverage commences immediately upon finalization of the adoption by an eligible Employee, or upon placement of the child pending adoption, provided the child has been properly enrolled in the Plan. "Placement" means the assumption and retention of a legal obligation for total or partial support in anticipation of adoption. Coverage for adopted children is identical to coverage for natural children.

(3) New Dependents (including legal spouses) added after you become covered under the Plan, will become eligible on the date of becoming your Dependent as long as you enroll him or her through the Administrative Office within 31 days of such date (for example the date of marriage or adoption). If Enrollment is not completed within 31 days of becoming eligible, the Dependent's effective date will be the date proper Enrollment is received by the Administrative Office.

(4) Newborn children are eligible for health care coverage from birth, including for mandatory Hospital stay benefits following birth. However, newborn children are not otherwise covered for charges for Hospital room and board during the first seven (7) days unless necessitated by a diagnosed sickness or injury.

NOTE: Health care benefits will cease at the end of a 31-day period unless the newborn child is enrolled under this Plan.

c. An eligible, unmarried Dependent child who becomes physically or mentally incapable before attaining 26 years of age may continue coverage under the Plan after attaining 26 years of age while remaining incapacitated, subject to the Employee's own coverage continuing in effect. The Plan will cover such child for a period of two (2) years or until Medicare coverage is activated, whichever occurs first. For eligibility to continue under this provision, proof of incapacity must be received by the Plan within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

d. Dependents may be eligible for Special Enrollment rights described in Part 2.E.

2. Required Evidence. You will be required to submit evidence to the Administrative Office of Dependent status such as a certified copy of the marriage certificate in the case of a new marriage; a certified copy of the birth record in the case of a newborn or natural child; certified copies of divorce and remarriage documents in the case of stepchildren; in the case of an adoption, a certified copy of the decree of adoption or certification of placement for adoption by a public or private agency making the placement; court order

for children under legal guardianship; or any other applicable evidence that the Trustees may in their sole discretion deem necessary before coverage can become effective.

3. Surrogacy Exclusion. Anything to the contrary notwithstanding, "Eligible Dependents" shall not include any child born as the result of any financial arrangement, whether denominated as a surrogate or not, whereby the parents of such child receive monetary or other compensation for conceiving and bearing such child for the purpose of placing such child for adoption or otherwise in the custody of others.

4. Coordinated Spousal Benefits. If your spouse is eligible as an Employee, he will be eligible both as an Employee and as a Dependent with coordinated benefits. When both husband and wife are covered as Employees, their children are Eligible Dependents of both with coordinated benefits.

5. Qualified Medical Child Support Orders ("QMCSO"). Sometimes a court or other agency will issue an order that an Employee covered under the Plan must enroll a child as a Dependent. The Plan will honor the order if it contains certain information required by law and is therefore a QMCSO. The procedures for QMCSOs are:

   a. Once the court or agency issues the order, the Employee or spouse sends the order to the Plan.

   b. The Administrative Office reviews to determine if the order is a QMCSO.

   c. The Plan notifies the child (through his parents), Employee and spouse (through their attorneys, if any) that the order has been received and is being reviewed.

   d. The Plan reviews the order to see if it is a QMCSO. The requirements of a QMCSO are—

      (1) the name of the Plan;

      (2) the name, address and social security number of the child to be enrolled in the Plan;

      (3) the exact time period that the child is to be enrolled; and

      (4) the order provides no requirements for eligibility or benefits that are not provided by the Plan.

   e. The Administrative Office notifies the child, Employee and spouse (through their attorneys, if any) whether the order is approved as a QMCSO or, if not, what changes need to be made.

   f. Once the QMCSO has been approved, the child will be enrolled under the terms of the Plan.

   g. Reimbursements and correspondence regarding claims for a child enrolled under a QMCSO may be sent directly to the child's guardian in accordance with the QMCSO.

D. **Special Initial Eligibility Rule for Relocating Employers**. Contributing Employers signatory to Collective Bargaining Agreements with Teamster local unions in other jurisdictions occasionally relocate their operations to within the jurisdiction covered by this Plan. In such cases, the Teamster employees of that Contributing Employer could incur a lapse or break in health and welfare coverage, despite the fact that their Contributing Employer is a signatory employer to a Teamsters Collective Bargaining Agreement. Therefore, Bargaining Unit Employees of such a Contributing Employer are eligible for immediate coverage under the Plan, provided—

1. the Contributing Employer was signatory to a Teamster Collective Bargaining Agreement and in good standing with another Teamster trust fund providing health and welfare benefits to the Contributing Employer's Teamster employees and is now signatory with the Plan;

2. the Employee seeking immediate eligibility was eligible for and covered by such other Teamster trust fund; and

3. in a Collective Bargaining Agreement, Teamsters Local 631 and the Contributing Employer have not provided for the prepurchase of eligibility for this category of Employees.

E. **Waiver of Initial Eligibility Requirement for New Employers**. The Board of Trustees, in its sole discretion, may grant immediate initial eligibility to Bargaining Unit Employees of new Contributing Employers first signatory to a Collective Bargaining Agreement with the Union, or others, in accordance with the following rules:

1. Hourly Rate Employees (Dollar Banks).

   a. A Bargaining Unit Employee who is employed by a newly-signatory Contributing Employer on the effective date of the Collective Bargaining Agreement will receive a loan of Bank dollars or hours sufficient to enable the Employee to acquire immediate eligibility for coverage. Unless otherwise approved by the Board of Trustees, such eligibility commences the first day of the month following the effective date of the Collective Bargaining Agreement. Hours thereafter worked or paid in Covered Employment by such an Employee and reported to the Plan will first be credited for current or ongoing eligibility. Hours remaining after the deduction for current eligibility and the application of the remaining surplus hours to reduce the loan will be done month by month until the loan is paid off. No hours will accumulate in any such Employee's hour or Dollar Bank for extended eligibility until the loan is retired.

   b. Bargaining Unit Employees hired by a newly-signatory Contributing Employer after the effective date of the Collective Bargaining Agreement are initially eligible for coverage in accordance with the standard eligibility rules of the Plan.

   c. If an Employee who acquired eligibility under this rule changes employment from a newly signatory Contributing Employer to any other signatory Contributing Employer before his hour or Dollar Bank loan or deficit is repaid in full, his reportable hours in new Covered Employment will continue to be

applied to pay off his hour or Dollar Bank loan or deficit, after first deducting sufficient hours for current eligibility.

d. If an Employee who acquired eligibility under this rule terminates employment before his hour or Dollar Bank loan or deficit has been repaid in full and does not become employed by another signatory Contributing Employer as stated in paragraph (c), coverage will end on the last day of employment.

2. Flat Rate Employees.

a. A Bargaining Unit Employee who is covered by a newly-signatory Contributing Employer on the effective date of the Collective Bargaining Agreement may receive immediate eligibility in the discretion of the Board of Trustees. Unless otherwise approved by the Board of Trustees, such eligibility commences the first day of the month following the effective date of the Collective Bargaining Agreement. Employees granted immediate eligibility do not receive coverage for the second month following termination of employment. For example, an immediately-eligible Employee who terminates in June will only have coverage through July, not August.

b. Employees newly hired after the effective date of the Collective Bargaining Agreement are initially eligible for coverage in accordance with the standard eligibility rules of the Plan.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 2. ENROLLMENT

In order to receive benefits under the Plan, all Active Employees, Retirees and Dependents must be enrolled. The following rules apply:

A. **Enrollment Materials.** If you are an Active Employee or Retiree, for you and your Dependents to be eligible to receive benefits under the Plan, it is mandatory that you submit accurate and completed Enrollment forms to the Administrative Office. Forms are available at the Administrative Office and at the Union office. After the Enrollment form is completed, return it to the Administrative Office. You will not be eligible, and no benefits will be available, unless a signed and properly completed Enrollment form is on file at the Administrative Office. You will not have dental benefit coverage until you enroll and select one of the two dental plan options (see Part 9).

B. **Beneficiary Designations**. An Employee must complete an Enrollment form to designate the Beneficiary for his death benefit and Accidental Death and Dismemberment Benefit. If the Employee wishes to change such a Beneficiary, he must get another blank form from his Union or the Administrative Office, fill it out completely and send it to the Administrative Office. Be sure to change a Beneficiary if needed as a result of a change in family status, such as a divorce.

C. Enrollment Agreement. By enrolling in the Plan and signing your Enrollment forms—

1. You certify and warrant to the Board of Trustees that all information on the Enrollment forms is true, complete and current as of the date signed. You agree to immediately notify the Board of Trustees, in writing, of any changes in this information, including any change in eligibility status for any Dependent listed on any Enrollment form. Failure to do so will be deemed an act or omission constituting fraud or an intentional misrepresentation of material fact by both the Active Employee or Retiree and Dependent. As a result, if the Plan has paid claims, both the Active Employee or Retiree and the Dependent are jointly and severally liable for those claims, and for all legal and other costs of the Plan incurred in obtaining recovery of the amounts paid by the Plan unless the former Dependent timely elects to receive continued COBRA coverage (see Part 5.A.). Receipt of Plan benefits is consent and agreement by the ineligible person to such liability.

2. You agree that the Board of Trustees has the right to require from you, and promptly receive from you, proof of eligibility status, such as marriage licenses, birth certificates, family court orders, tax returns or any other proof of eligibility or information as the Board of Trustees, in its sole discretion, may request. You agree to promptly furnish such proof or information to the Board of Trustees, and you further agree that furnishing such proof or information satisfactory to the Board of Trustees is a precondition to the eligibility or payment of any benefits for you or your Dependents. You understand and agree that health care benefits are not vested rights and that the Board of Trustees has full authority to modify, limit or terminate health care benefits at any time the Board of Trustees deems appropriate.

3. If the Plan pays benefits for you or on your behalf or on behalf of any person listed as a Dependent on your Enrollment forms, when you or any such person is not in fact eligible or entitled to benefits, or if the Plan otherwise mistakenly pays benefits, you agree to

promptly reimburse the Plan in full for any money so paid. You also agree that the Trustees, in their sole discretion, may deduct or offset any such money from your future benefits. If the Plan files any legal action against you to recover any such money, you agree to pay all attorneys' fees and costs of the Plan, whether or not such an action proceeds to judgment, and post-judgment interest on any such judgment shall be at the Plan's delinquent Contribution interest rate, not the statutory rate.

D. **Open Enrollment**. The Plan provides an opportunity once each year during Open Enrollment for Plan Participants to change medical and dental Plan coverage, and at such other times as determined by the Trustees. Open Enrollment is generally in June of each year for changes effective July 1. You may select either the Indemnity Medical Plan (PPO) or the EPO Plan and either the Dental PPO Plan or the Managed Care Dental Plan.

E. Special Enrollment.

1. Dependents may be enrolled year-round by an enrolled Active Employee.

2. If you decline Enrollment for yourself or your Dependents (including your spouse) because of other health benefits coverage or insurance, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request Enrollment within 31 days after your other coverage ends.

3. In addition, if you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents, provided you request Enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

F. **Additional Special Enrollment Rights**. If you did not enroll in this Plan when you were first eligible, you are also allowed to enroll pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP"), if:

1. You or your Dependent loses coverage and eligibility under a Title XIX Medicaid plan or under a Title XXI State child health plan and you request coverage in this Plan not later than 60 days after the date of termination of the other coverage; or

2. You or your Dependent becomes eligible for CHIP assistance to offset the cost of participating in this Plan, provided you request coverage under this Plan not later than 60 days after the date you or your Dependent is determined to be eligible for CHIP assistance.

G. **False Information and Fraud**. If an Employee or Dependent knowingly submits false information or knowingly fails to timely submit or conceals material information in order to achieve eligibility or obtain any benefit from the Plan, or otherwise commits fraud on the Plan as determined solely by the Trustees, the Plan, in addition to any other legal remedies or legal recourse it may have, may deny benefits or revoke coverage or eligibility for such time and on such terms as they deem just and appropriate. **Receipt of Plan benefits is consent and agreement by the Employee and ineligible person to such liability**.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 3. START OF COVERAGE AND CONTRIBUTIONS

A. Start of Coverage. You and your Eligible Dependents will first become covered under the Plan on the first day of the second calendar month after your Contributing Employer has paid two (2) consecutive full months' Contributions into the Plan for you (see example in Part 1.A.2). If coverage terminates under this Plan and you later return to work for a Contributing Employer, you and your Dependents will become eligible on the first day of the second month following a full month's Contribution that the Contributing Employer is obligated to make on your behalf (see example in Part 4.C).

B. **Contributions for Continuing Coverage**. Once coverage has started, you and your Eligible Dependents will continue to have coverage as long as the required Contribution is made, either by your Contributing Employer or (if permitted) by you.

1. Crediting Contributions and Dollar Banks. Your Contributing Employer is required to make an hourly and/or flat rate Contribution on your behalf. You and your Eligible Dependents will be eligible for benefits for the month in which you have sufficient funds in your Dollar Bank (after crediting Contributions applicable to coverage for that current month) to withdraw the required amount for coverage. Except for those Employees working in the Convention Industry, funds in excess of the required monthly amount and the initial reserve month will accumulate in your Dollar Bank. Eligible Employees are entitled to maintain dollars in the Bank up to a maximum of 12 months' coverage, based on the cost of benefits as determined in the sole discretion of the Board of Trustees. Any dollars accumulated in excess of the amount needed for 12 months' coverage are forfeited to the Plan. If there are not sufficient hours or amounts in a participant's Dollar Bank to cover the difference necessary to maintain eligibility, refer to Part 3.B.6 below.

   EXCEPTION: Convention Industry workers must work at least 100 hours per month in order to maintain continuing eligibility to be eligible under the Plan. Hours worked in excess of 100 hours per month are attributed to the Convention Industry Active Employee's Dollar Bank, subject to the Dollar Bank maximum. If an Active Employee in the Convention Industry works less than 100 hours in a month and does not have enough credit in their Dollar Bank, or does not Self-Pay the difference, the hours less than 100 hours are forfeited.

2. Insufficient Dollar Bank. If, after you achieve initial eligibility, you fail to maintain sufficient dollars in your Dollar Bank and lose eligibility for any three (3) consecutive months, any dollars credited to your Dollar Bank will be forfeited and cancelled. Your Dollar Bank will continue to include amounts accrued in the previous two (2) months unless and until they too become subject to forfeiture under this rule.

3. Dependent Use of Dollar Bank. An eligible surviving spouse or child of a deceased Active Employee may use the Active Employee's remaining Dollar Bank for continued eligibility or continuation of coverage before exercising any right to COBRA or Self-Payment coverage. A surviving spouse of a deceased Active Employee who at the time of the Employee's death was covered under the Plan may elect to continue coverage until exhausting the Employee's Dollar Bank and COBRA eligibility and thereafter at such rates as determined in the sole discretion of the Board of Trustees. Upon attainment of the age for Medicare eligibility, such surviving spouse must transfer to the EPO Plan.

4. Hours Credited to Dollar Bank. In some cases, a Collective Bargaining Agreement may include special provisions regarding the accumulation of hours in a Dollar Bank and use of those hours. Such special provisions may, in the sole discretion of the Trustees, be applied to Employees participating under such Collective Bargaining Agreements.

5. No Vested Benefits. Dollar Banks are not vested, guaranteed or unchangeable benefits. Dollar Banks may be reduced or eliminated, retroactively or prospectively at any time in the sole discretion of the Trustees based on the financial condition of the Plan.

6. Use of Dollar Bank When Hours Worked is Insufficient. If you are a Construction Industry Participant and do not work enough hours to maintain eligibility in a given month, the difference needed to maintain eligibility will be deducted first from your Dollar Bank at the employer's contribution rate. If there is not a sufficient amount in your dollar bank to cover the difference necessary to maintain eligibility, you may self-pay the difference at the hourly COBRA rate.

   If you are a Convention Industry Participant and work less than 100 hours in a given month, the difference in hours is deducted from the Dollar Bank at the employer's contribution rate necessary to achieve the equivalent of 100 hours for that month, if available. If the balance in your Dollar Bank is insufficient to cover the remaining hours due to achieve 100 hours and you wish to continue coverage, you may self-pay the difference in hours at the hourly COBRA Rate.

C. **Delinquent Contributions**. If there is good and sufficient evidence, as determined in the sole discretion and judgment of the Trustees, that an Employee has performed Covered Employment for a certain number of hours, the Plan will credit those hours even though the Contributing Employer has not paid the required Contribution in the following cases:

1. Where the work was performed within the last three (3) months, the hours will be treated as worked in the month the actual work took place; and

2. Where the work was performed more than three (3) months prior, the Trustees have discretion based on reasonable criteria they apply to credit the hours to months other than the months in which the actual work occurred in order to prevent a loss of eligibility and coverage.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 4. TERMINATION OF COVERAGE

A. **Termination of Eligibility and Benefits**. All the benefits will terminate—

1. if the Employee ceases to be eligible under Part 1;

2. on the date the Employee enters active full-time military service;

3. upon termination of this Plan;

4. on the last day of the calendar month for which a required Contribution is made, either by the Employee's Contributing Employer or because the Employee's reserve Dollar Bank is depleted; but this criteria will not apply if the Employee continues to pay for coverage under Retiree Self-Payment coverage (Part 12), under the continuation of coverage (COBRA) rules (see Part 5); or,

5. in the case of a Dependent, when he is no longer an Eligible Dependent or

   a. when a request to disenroll is based on the availability of other coverage and is approved by the plan; or

   b. when a request to disenroll a Dependent spouse is based on a signed court order for legal separation or divorce.

B. Special Rules Regarding Termination of Eligibility.

1. An Employee or Dependent cannot voluntarily terminate plan coverage except pursuant to the express provisions of the Plan.

2. If an Employee engages in covered work for a nonparticipating employer, he will immediately forfeit all dollars in his Dollar Bank. If he had previously established eligibility for benefits during the month in which he began covered work for a nonparticipating employer, he will retain eligibility only through the end of that month. He may maintain eligibility under the Plan only by electing COBRA continuation coverage and paying the applicable required .

3. The Employee and his or her ex-spouse is obligated to promptly and timely notify the Plan through the Administrative Office of any divorce by providing both written notice thereof and a copy of the divorce decree. Failure to do so will be deemed an act or omission constituting fraud or an intentional misrepresentation of material fact by both the Employee and former spouse. As a result, if the Plan has paid claims, both the Employee and the former spouse will be jointly and severally liable for those claims, together with all of the costs incurred by the Plan including attorneys' fees and court costs in recouping Plan benefits paid in connection with such claims. **Receipt of Plan benefits is consent and agreement by the ineligible person to such liability.**

C. **Reinstating Coverage**. If your coverage terminates under this Plan and you later return to work for a Contributing Employer, you and your Dependents will become eligible on the first day of the second month following a single full month's Contribution that the Contributing Employer is obligated to make on your behalf.

Example: You return to work for a Contributing Employer in January. You work enough hours in January to qualify for a Contribution to be made on your behalf in February (the reporting "lag" month). You are then eligible for coverage to begin March 1.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 5. CONTINUATION OF COVERAGE

A. **COBRA Continuation Coverage Description and General Notice**. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. You may elect to continue medical, dental, vision, and Prescription Drug coverage. (Neither life insurance nor Accidental Death and Dismemberment insurance are available under COBRA.) You, your spouse, and Dependents should take the time to read this section carefully.

For additional information about your rights and obligations under the Plan and under federal law, you should contact the Administrator.

1. Length of COBRA for the Employee and his or her Dependents. You may be eligible to keep coverage for yourself and your covered Dependents for up to 18 months if you lose coverage for one of the following qualifying events:

   a. Your employment with a participating employer ends for any reason other than gross misconduct.

   b. Your work hours are reduced below the number of hours that you need to be eligible for coverage.

2. Length of COBRA for Dependents Only. Your covered Dependents may be eligible to extend their coverage for up to 36 months if they lose their coverage for one of these reasons:

   a. You die while you are covered under the Plan.

   b. You and your spouse legally separate or divorce.

   c. You become entitled to receive benefits under Medicare and, within 18 months after becoming entitled to Medicare, you leave Covered Employment or have your hours reduced causing a loss of coverage.

   d. Your Dependent reaches age 26, enters the armed forces, or otherwise fails to meet the eligibility requirements.

   e. Each Dependent has a separate right to coverage. For example, your spouse could choose not to enroll himself or herself, but enroll your Dependent children.

3. Extension of COBRA Coverage for a Second Qualifying Event. Each of the reasons you can become eligible for COBRA listed above are called "qualifying events." If you have coverage under COBRA, and then you have a second qualifying event, you may extend your coverage by another 18 months, for a total of 36 months from the date your original COBRA coverage began. To be eligible for this extended coverage, you must notify the Administrative Office of the event, in writing, within 60 days of the second qualifying event.

4. Extension of COBRA for Social Security Disability Eligibility. The 18-month COBRA period may be extended 11 months (for a total of 29 months of coverage) if you or a

covered Dependent receive a ruling from the Social Security Administration that you or your covered Dependent were totally disabled during the first 60 days following your loss of employment or reduction in hours.

a. To be eligible, you must provide the Administrative Office with a copy of the Social Security Administration's determination of disability within 60 days of the Social Security ruling, and within the initial 18-month COBRA period.

b. During the 11-month extension period, you pay the entire COBRA rate, plus up to a 50% administrative fee. Nondisabled family members, who are covered during the COBRA period, are also entitled to the additional 11 months of COBRA coverage.

5. Notification of COBRA Eligibility. If your coverage ends because your employment ended or your hours were reduced, you will receive the necessary Enrollment materials from the Administrative Office. If any of your Dependents lose eligibility for Plan coverage while you are covered, you are responsible for notifying the Administrative Office within 60 days of the date his or her eligibility ends. If you die, or you divorce your spouse, the former Dependent must call or write the Administrative Office within 60 days. The Administrative Office will send your former Dependent COBRA coverage enrollment materials.

6. Enrollment Period. You or your Dependent has 60 days to complete the COBRA coverage application and return it to the Administrative Office. This 60-day period begins on the latest of the following dates:

a. The date Plan coverage ends; or

b. The date you or your Dependent is told, in writing, of the right to keep coverage under COBRA.

If the Administrative Office does not receive the application by the end of the 60-day period, you and your Dependent will lose the right to coverage under COBRA. For example, if your coverage ends on March 31 and you receive notice of your COBRA rights on April 14, you have 60 days, or until June 14, to complete and return a COBRA coverage application to the Administrative Office. If you miss that deadline, you lose your right to COBRA coverage. If you return the application by June 14 (the 60-day deadline) you then have 45 days, or until July 29, to make your first payment for COBRA coverage. If you wait until July 29 to make your first payment, you will owe four (4) months of payments for April, May, June and July.

c. If you return the COBRA coverage application within 60 days, you must pay your cost for the current month of coverage, plus back-payments for the months since losing your coverage, and administrative charges, within the next 45 days. If you do not make that payment in 45 days you and your Dependents will lose the right to coverage under COBRA.

d. Payment Obligations.

(1) All payments must be made by check, cashier's check or money order. Your initial payment must cover the months since your Plan coverage ended, and the month in which the initial payment is made. After your first payment is made, you must make the payments monthly.

(2) To avoid delays in claim payments and eligibility problems, you should have your payments to the Administrative Office no later than the 20th day of the month before the covered month. You must make the payment no later than the 30th day of the month for which you seek coverage. If no payment is made by that date, your coverage will be cancelled as of the last day of the prior month, and you lose the right to COBRA coverage.

The Administrative Office does not send bills or warning notices. It is your responsibility to submit payments when due.

7. Cost of COBRA Coverage. You, and your covered Dependents who keep their coverage under COBRA, pay the entire cost of COBRA benefits, plus an administrative fee. During the regular 18-month or 36-month coverage, the administration fee equals 2% of the monthly cost. During the 11-month Social Security disability extension, the administration fee is 50% of the monthly cost.

When you are covered under COBRA, you have the same health care expenses covered (depending on the level of coverage you select), and pay the same costs (except you also pay a monthly COBRA administration fee), as Active Employees. If, in the future, the Contributions, Copayments, Coinsurance, Deductibles or services, etc. change for Active Employees, your coverage will change in the same manner.

8. Enrolling New Dependents. If you and/or your spouse are covered under COBRA, you can add new Dependents to COBRA coverage the same way you add new Dependents if you were an Active Employee. If you enroll your new Dependent within 90 days of marriage, birth, adoption or placement for adoption, coverage will be retroactive back to the date of marriage, birth or placement. If you enroll your new Dependent later than 90 days after the marriage, birth or placement for adoption, coverage will be effective the first day of the following month. To enroll your new Dependents, you must complete a new Enrollment card and supply any documentation the Administrative Office requires.

Please note that a newly-enrolled Dependent may only be covered for as long as you or your spouse is eligible to be covered, (the remainder of your COBRA coverage period), and as long as payments are made.

9. End of COBRA Coverage. COBRA coverage ends on the first of the following dates:

a. The last day of the month for which the payment for COBRA coverage has been made in full (and no later than 30 days past the due date);

b. If you become entitled to Medicare (for yourself), your Dependents are still eligible for coverage under COBRA (and this becomes your second qualifying event for your Dependents);

c. The date you become covered under another group health plan;

d. The last day of the COBRA coverage period (18, 29, or 36 months). If coverage is extended because of disability, the date 30 days after the Social Security Administration determines that the disability has ended;

e. The date the Plan no longer offers any group health care plan.

Once COBRA coverage ends, it cannot be started again.

Note that the maximum 18 or 36 months of COBRA continuation coverage will include (and the formal COBRA coverage period will be reduced by) any Self-Payment coverage provided by the Plan in case of death of the Active Employee or Retiree.

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

Notice: The next page is the general COBRA notice required by law.

Continuation of Health Coverage Notice and Election Procedure

General Notice (Initial COBRA Notice):

A group health plan subject to the requirements of COBRA must provide written notice to each covered employee and spouse (if applicable) within 90 days after coverage under the Plan commences of the right to continue coverage. (If a Qualifying Event occurs during the first 90 days of coverage under the Plan and before the general notice has been distributed, the Plan may provide only the COBRA election notice, as described below). In lieu of, or in addition to, such written notice, the Plan Administrator is hereby providing the general notice to the employee by delivery of the Summary Plan Description.

The Plan may notify a covered employee and the covered employee's spouse with a single general notice addressed to their joint residence, provided the Plan's latest information indicates that both reside at that address. However, when a spouse's coverage under the Plan begins later than the employee's coverage, a separate general notice must be sent to the spouse within 90 days after the spouse's coverage commences.

NOTE: It is important for the Plan Administrator to be kept informed of the current addresses of all Covered Persons under the Plan who are, or who may become Qualified Beneficiaries.

Employer's Notice of Qualifying Event And Notices That Qualified Beneficiaries Must Provide:

Continuation of health coverage shall be available to an employee and/or his covered dependents upon the occurrence of a Qualifying Event. To continue health coverage, the Plan Administrator must be notified in writing of a Qualifying Event by:

1. The Employer, within 30 days of the later of: (1) the date of such event or (2) the date of loss of coverage due to the event, if the Qualifying Event is:

a. for a covered dependent, the covered employee's death;

b. the covered employee's termination (other than for gross misconduct) or reduction in hours;

c for a covered dependent, the covered employee's entitlement to Medicare.

d. the commencement of certain bankruptcy proceedings with respect to the Employer.

2. The employee or a Qualified Beneficiary, within 60 days of the later of: (1) the date of such event, (2) the date of loss of coverage due to the event, or (3) the date on which a Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both his obligation to provide notice and the procedures for providing such notice, if the Qualifying Event is:

a. for a spouse, divorce or legal separation from a covered employee;

b. for a dependent child, loss of dependent status under the Plan; or

c. the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

An employee or Qualified Beneficiary who does not provide timely notice to the Employer of one of the above such Qualifying Events may lose his rights under COBRA.

Upon termination of employment or reduction in hours, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date, or at any time during the first 60 days of COBRA continuation coverage, will be entitled to continue coverage for up to 29 months if the Plan Administrator is notified of such disability within 60 days from the later of (and before the end of the 18-month period): (1) the date of determination, (2) the date on which the Qualifying Event occurs, (3) the date on which the Qualified Beneficiary loses coverage, or (4) the date on which the Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both the obligation to provide the disability notice and the Plan's procedures for providing such notice. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

A Qualified Beneficiary who is disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the later of: (1) the date of final determination that he is no longer disabled, or (2) the date on which the individual is informed through the Plan's Summary Plan Description or general notice of both the responsibility to provide such notice and the Plan's procedures for providing such notice.

Plan Administrator's Notice Obligation - Election Notice:

The Plan Administrator must, within 14 days of receiving notice of a Qualifying Event, notify any Qualified Beneficiary of his right to continue coverage under the Plan. Notice to a Qualified Beneficiary who is the employee's spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Election Procedures:

A Qualified Beneficiary must elect Continuation of Health Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A new spouse, a newborn child, or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the "Special Enrollment" section of the Plan. A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time and in accordance with the procedures established by the Plan Administrator.

Any election by an employee or his spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contributions to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a 30-day grace period. If the initial contribution payment is not made within 45 days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted 30-day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

Except as provided herein, if the initial coverage election and required contribution payments are made in a timely manner, as described in this section, coverage under the Plan will be reinstated retroactively back to the date of the Qualifying Event.

If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements, such as timely contribution payments, are met.

Plan Administrator's Notice Obligation - Notice of Unavailability of Continuation Coverage:

The Plan Administrator must provide a notice of unavailability to an individual within 14 days after receiving a request for continuation coverage if the Plan determines that such individual is not entitled to continuation coverage. The notice must include an explanation as to why the individual is not entitled to COBRA. This notice must be provided regardless of the basis of the denial and regardless of whether it involves a first or second Qualifying Event or a request for disability extension.

Plan Administrator's Notice Obligation - Early Termination Notice:

The Plan Administrator must provide a notice to Qualified Beneficiaries when COBRA terminates earlier than the maximum period of COBRA applicable to the Qualifying Event as soon as practicable following its determination that continuation coverage shall terminate. This notice must contain the reason that continuation coverage has terminated earlier than the maximum period triggered by the Qualifying Event, the date of termination of continuation coverage, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage (such as a conversion right).

Trade Act of 2002:

The Plan shall fully comply with the Trade Act of 2002 as the Act applies to employee welfare benefit plans.

B. Special Continuation of Indemnity Medical Benefits Coverage – Disability.

1. If you are covered under the Indemnity Medical Plan and are certified as totally disabled under the Plan when coverage would otherwise terminate, medical benefits under the Indemnity Medical Plan will continue in force for covered expenses incurred relating to treatment of the sickness or injury causing the disability, without payment, for a period of up to 12 months. This extension of coverage will end earlier than 12 months if you are no longer totally disabled or you become eligible for medical coverage under any other group plan.

2. A Dependent who is totally disabled when coverage terminates is also eligible for this continuation of coverage according to the same provisions stated above.

3. The benefits payable during the period the coverage is extended will not exceed the balance of the overall Plan maximum remaining available to the individuals at the start of the extended period.

4. When this extension applies, it will operate only to the extent that coverage for medical care is not otherwise provided for the person through the Plan.

5. The term totally disabled means "disabled" as determined by the federal Social Security Administration, resulting in the individual's entitlement to a Social Security disability benefit.

NOTE: If you want coverage for any sickness or illness other than the condition causing the disability, you must elect and pay for COBRA, if eligible.

C. Military Leave and USERRA Rights.

1. Continuation of Coverage During U.S. Military Leave. Federal law ("USERRA") gives you certain rights if you voluntarily or involuntarily leave Covered Employment to serve in any of the United States uniformed military services, including the Coast Guard, for active duty or training. To qualify for these rights, you must give the Administrative Office advance written or verbal notice of your upcoming leave for military service and you must report back to work within certain time periods, depending on the length of your military service. In no event shall benefits be provided for sicknesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performances of services in the uniformed services.

    a. Unless the terms of your Collective Bargaining Agreement required otherwise, you may maintain coverage for yourself and your Dependents for the lesser of:

        (1) 24 months from the day your absence begins; or

        (2) The day after the date on which you could have applied for, or returned to, Covered Employment.

    b. This continuation is subject to payment of the full Contribution for coverage plus any additional amount permitted by law. The Contribution will change whenever the Plan's costs change. If your absence is 31 days or less, your latest employer

will pay their usual share of the required Contribution; for any longer absence, you are responsible for the entire payment.

c. While you are on leave, your employer will provide (through Contributions) any seniority-based benefits to which you are entitled because of USERRA. If you return to work within the time limits, your benefits will be reinstated as though you had worked through your entire leave period. USERRA leave will not cause you to lose any benefits you have accumulated up to the date of your leave. If your last employer is no longer in business or functional when you are on leave, the benefits will be provided by the Plan at its own expense.

2. Termination of Continuation Coverage. This continued coverage will terminate when—

a. the former Active Employee or other COBRA beneficiary does not make the required payment when due;

b. the cumulative length of the absence and all previous absences from a position of employment with that employer for military service exceeds five (5) years;

c. a dishonorable or bad conduct discharge is received, an other than honorable separation, a dismissal under 10 U.S.C. § 1161 (a), or a dropping from the rolls under 10 U.S.C. § 1161 (b); or

d. the maximum period of coverage expires. The maximum period of coverage shall be the lesser of (1) the 24-month period beginning on the date on which absence begins; or (2) the date after the date on which failure to apply for or return to a position of employment occurs, as required by USERRA.

3. Coverage upon Reemployment Following Military Service. If an Active Employee's coverage terminates under the Plan by reason of his military service, the Active Employee will become eligible for benefits on the first day he is reemployed by a Contributing Employer in the Plan. The requirements for this eligibility are—

a. the former Active Employee and the military must give advance written or verbal notice of uniformed service to the Plan;

b. the cumulative length of the absence and all previous absences from a position of employment with Contributing Employers for military service does not exceed five (5) years;

c. the former Active Employee applies for reemployment or returns to a position of employment within the time allowed by USERRA; and

d. the former Active Employee does not receive a dishonorable discharge, a bad conduct discharge, or other than an honorable separation, a dismissal under 10 U.S.C. § 1161(a), or a dropping from the rolls under 10 U.S.C. § 1161 (b).

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 6. MEDICAL PLAN OPTIONS

Also refer to the *Quick Guide to Benefits* beginning on page 3.

A. Two Medical Benefit Options: Indemnity (PPO) and EPO

The Plan offers two benefit options: (1) the Indemnity Medical or ***PPO*** Plan and (2) the Exclusive Provider Organization Plan ("***EPO***").

Except for Retirees, if you are otherwise eligible for coverage under the Plan, you may elect to be covered under the Indemnity Medical Plan or the EPO. You will have an opportunity to make a benefit option selection and enroll in either the Indemnity Medical Plan or the EPO when you are first eligible. Thereafter, changes can be made during Open Enrollment. Further information is available at the Administrative Office whose address and telephone number are listed in the Quick Guide to Important Contacts. Active Employee Participants who do not select the EPO option will be covered by the Indemnity Medical Plan.

Retirees are only eligible to enroll in the EPO. The Indemnity Medical Plan Benefits are not available to Retirees.

Indemnity Medical Plan: Under the Indemnity Medical Plan, you may choose any Doctor or Hospital when you or an eligible member of your family needs medical care. You are not required to select or designate a primary care provider. You have the ability to visit any PPO or Non-PPO Provider. However, except for Emergency Services, air ambulance services, and certain ancillary services performed by a Non-EPO Provider in certain participating facilities, payment by the Plan will be less for the use of a Non-PPO Provider.

EPO: If you enroll in the EPO, you are not required to select or designate a primary care provider. You have the ability to visit any Contracted Provider. When you obtain covered medical services from an EPO Provider, you have broad coverage with minimal out-of-pocket expenses, often limited to only a Copayment. Except for Emergency Services, air ambulance services, and certain ancillary services performed by a Non-EPO Provider in certain participating facilities, if you visit a Non-EPO Provider, the Plan will not provide any coverage.

For retirees, when you or your spouse reach age 65 or otherwise become Medicare Eligible, whether or not you have retired and applied for Social Security benefits, you must be certain to enroll for Medicare Part A and Part B benefits at your Social Security office. This is vitally important to you because your benefits with this Plan will not duplicate any benefits you are legally entitled to receive.

Unless otherwise indicated, the benefit terms in this Section apply to both the Indemnity Medical Plan and the EPO benefit options.

B. Network and Non-Network Providers Comparison.

To obtain the maximum possible benefits from the Plan you must use Contracted Providers. Contracted providers and facilities have agreements with the Plan under which they provide covered health care services and supplies for a favorable negotiated discount fee for our plan participants. Your lowest out-of-pocket costs occur when you use a Contracted provider/facility.

For the Indemnity Medical Plan, you should aim to obtain services from PPO Providers. As described in the Coinsurance and Copayments section below, you obtain the maximum possible benefits from the Indemnity Medical Plan when you receive services from PPO Providers. Payments to Non-Network Providers are limited to Allowable Expenses after application of your cost-sharing which includes the Deductible, Copayments and/or Coinsurance. With the exception of Emergency Services, air ambulance services, and certain ancillary services performed by a Non-PPO Provider in certain participating facilities, you will be responsible for any amounts charged in excess of Allowable Expenses for Non-Network Providers in addition to other applicable Participant cost-sharing such as deductibles, copayments or coinsurance.

For the EPO, you must obtain services from EPO Providers. Except for Emergency Services, air ambulance services, and certain ancillary services performed by a Non-EPO Provider in certain participating facilities, the Plan will not cover any services for an enrollee in the EPO plan that are provided by a Non-EPO Provider.

Please contact the Medical Preferred Provider Network listed in the Quick Guide to Important Contacts for a list of facilities and professionals in the PPO or EPO network. From time to time we update the list of PPO or EPO networks with whom we contract and you will be notified of changes. Also, the Administrative Office can help you locate a PPO or EPO provider/facility.

If you are referred to a lab for tests, or a specialist for specific diagnosis or treatment, ask whether the lab or specialist is a Network Provider.

Special Reimbursement Provision for Indemnity/PPO Plan: The following explains the Plan's special reimbursement for services when certain non-network providers are used by a Participant enrolled in the PPO option. 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 a special reimbursement provision. The Plan will reimburse a non-network provider claim at the in-network provider benefit level if:

1. There are no appropriate in-network providers in the community where the care is received and the participant has to travel more than **50 miles** to the nearest in-network provider, or

2. The services that were provided were Emergency Services, as defined in this Plan, air ambulance services, or for certain ancillary services performed by a Non-PPO Provider in certain participating facilities

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

If for any reason you are going to see another Doctor in your Doctor's office, find out first whether the new Doctor is a Network Provider. Physicians in the same office do not always accept the same insurance plans.

Contact the Preferred Provider Network as directed in the Quick Guide to Important Contacts with any questions regarding Network Providers.

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

C. How to Choose a Network Provider:

For a complete list of Network providers, see the website of the Preferred Provider Network located on the Quick Guide to Important Contacts in the front of this document.

You can find an Anthem Blue Cross network provider online. Here's how:

- Go to www.anthem.com.
- Click on the Menu on the upper left side of the web page.
- Select "Find A Doctor" under the Care section in the middle of the page.
- Under "Search as a Member," go to the OR section where it asks for "Identification number or prefix (first three values)" and enter "JTL".
- Then you can find a provider in the network by entering the type of provider, the specialty of the provider, and your location. You can also limit the selection to those doctors who are accepting new patients.

D. **Deductible**.

A Deductible is the amount you have to pay before Plan benefit payments begin.

The Quick Guide to Indemnity Medical Plan Benefits includes Deductibles that apply under the Indemnity Medical Plan. This information is also explained below. There are no Deductibles that apply under the EPO.

1. Deductibles.

   a. Hospital Admission. Admission to a Hospital or Skilled nursing facility requires a $100 Deductible per admission at a Network Provider, or a $600 Deductible per admission at a Non-Network Provider (but if an emergency admission at a Non-Network Provider Hospital, then the $100 Network Deductible applies).

   b. Calendar Year Deductible on Other Services. No Deductible is required for other Network Provider expenses. The Calendar Year Deductible (Non-Network Providers only) is $500 per person (up to a maximum of $1,500 per family of three or more) and must be paid toward eligible expenses before benefits are payable under the Plan.

2. How the Deductible Works.

a. The Deductible is not reduced for Copayments or Coinsurance.

b. Admissions to a Network Provider Hospital, or skilled nursing facility require a $100 Deductible per admission. Admissions to an inpatient rehabilitation facility require a $100 Deductible per admission, but the Deductible is waived if you are admitted from an acute facility. Admissions to a Non-Network Provider Hospital require a $600 Deductible for each admission (but if an emergency admission at a Non-Network Provider Hospital, then the $100 Network Deductible applies). Admissions to a Non-Network inpatient Hospice require a $600 Deductible for each admission. No coverage is provided for Non-Network skilled nursing facilities.

c. The Copayments or Deductibles made to Network Providers may not be used toward satisfying the Non-Network Provider Deductibles.

d. The Non-Network Provider Calendar Year Deductible needs to be satisfied only once per individual during a Calendar Year even though the individual has several Accidents and sicknesses.

e. The Calendar Year Deductible must be satisfied by eligible expenses incurred during that Calendar Year. However, any eligible expenses incurred during the last three (3) months of the Calendar Year that were applied against that year's Deductible (whether or not the full Deductible was accumulated for that year) will also be applied toward the Deductible for the next year and thus reduce or eliminate the next year's Deductible. The Deductible carryover is applied only on an individual basis and not on a family Deductible basis.

f. If two (2) or more covered family members are injured in the same Accident, only one (1) Calendar Year Deductible will be charged to their combined eligible expense due to the Accident.

E. **Coinsurance**.

1. Indemnity Medical Plan: The Indemnity Medical Plan primarily provides for benefits subject to Coinsurance. After you (or a covered Dependent) have satisfied the Calendar Year Deductible, the Plan will pay the percentage of benefits specified in the Quick Guide to Benefits and below, subject to reduction if you do not receive Prior Authorization or Continued Stay Review when applicable. The remaining part that you pay is called "Coinsurance".

a. *Percentage Determined by Provider Selected.*

(1) Services Performed by a PPO Provider. As indicated in the Quick Guide to Benefits, for certain benefits the Plan pays 80% of Allowable Expenses. The remaining part of the cost that you pay is called "Coinsurance."

(2) Services Performed by a Non-Network Provider. The Plan pays 50% of Allowable Expenses, subject to reduction if you do not receive Prior Authorization or Continued Stay Review when applicable. You will be responsible for any amounts charged in excess of Allowable Expenses for Non-Network Providers.

b. *Coinsurance Limit (Out-of-Pocket Maximum*).

(1) Network Providers. The Plan limits out-of-pocket eligible Network Provider expenses for Coinsurance each year to $2,500 for each covered individual and $5,000 for a covered family, not including Deductibles and Copayments.

(2) Non-Network Providers. The Plan does not limit out-of-pocket eligible Non-Network Provider expenses.

Where it is Medically Necessary and appropriate for an eligible Participant to have medical services otherwise covered by the Plan but that are not reasonably available through current Network Providers, and the Participant proves this to the satisfaction of the Board of Trustees based upon whatever evidence the Board of Trustees may require, the Trustees may, in their sole discretion waive the Non-Network Provider Calendar Year Deductible, but Non-Network Provider Coinsurance will still apply.

2. EPO: The EPO Plan primarily provides for benefits with EPO Providers subject to payment of a set Copayment. With the exception of Emergency Services, air ambulance services, or for certain ancillary services performed by a Non-EPO Provider in certain participating facilities, if you obtain nonemergency services from a Non-EPO Provider, the Plan does not cover the services and you will be responsible for the full amount of the charges.

F. Annual Out-of-Pocket Maximum on Essential Health Benefits.

1. Indemnity Medical Plan: If you are enrolled in the Indemnity Medical Plan.

a. *Services performed by a PPO Provider*: Your annual out-of-pocket maximum for Allowable Expenses for Essential Health Benefits provided by a PPO Provider will not exceed $6,600 per person or $13,200 per family. This annual out-of-pocket maximum includes all Copayments, cost-sharing and Deductibles under the Indemnity Medical Plan. The Plan's Out-of-Pocket Coinsurance Limit described above only applies to Coinsurance amounts for covered services. In contrast, once you or your family meet the Annual Out-of-Pocket Maximum. the Plan will not charge any additional Copayments, Coinsurance or Deductibles for Essential Health Benefits.

b. *Services performed by a Noncontracted Provider*: After the Calendar Year Deductible, the Plan generally pays 50% of the Plan’s Allowable Expenses. Except for Emergency Services, there is no out-of-pocket Calendar Year maximum when using Non-PPO Providers.

c. Amounts paid for Non-PPO Emergency Services, Non-PPO air ambulance services, and for certain ancillary services performed by a Non-PPO Provider in certain participating facilities will accrue towards you PPO Provider Out of Pocket Maximum.

2. EPO: If you are enrolled in the EPO and are not eligible for Medicare.

a. *Services performed by an EPO Provider*: Your annual out-of-pocket maximum for Allowable Expenses for medical and Prescription Drug benefits under the EPO provided by EPO Providers is $6,250 for an individual, $12,000 for a family. This annual out-of-pocket maximum includes all Copayments and Coinsurance under the EPO.

b. *Services performed by a Non-EPO Provider*: The EPO does not cover any charges for non-Emergency Services performed by a Non-EPO Provider. Except for Emergency Services, there is no annual out-of-pocket maximum when using Non-EPO Providers.

c. Amounts paid for Non-EPO Emergency Services, Non-EPO air ambulance services, and for certain ancillary services performed by a Non-EPO Provider in certain participating facilities will accrue towards you EPO Provider Out of Pocket Maximum.

3. EPO: If you are enrolled in the EPO and are eligible for Medicare.

a. *Services performed by an EPO Provider*: Your annual out-of-pocket maximum for Allowable Expenses for medical benefits under the EPO provided by EPO Providers is $2,500 per individual. This annual out-of-pocket maximum includes all Copayments and Coinsurance for medical services under the EPO. It does not include any copayments or coinsurance for prescription drug benefits; there is no out-of-pocket maximum for these benefits.

b. *Services performed by a Non-EPO Provider*: The EPO does not cover any charges for non-Emergency Services performed by a Non-EPO Provider. Except for Emergency Services, there is no annual out-of-pocket maximum when using Non-EPO Providers.

c. Amounts paid for Non-EPO Emergency Services, Non-EPO air ambulance services, and for certain ancillary services performed by a Non-EPO Provider in certain participating facilities will accrue towards you EPO Provider Out of Pocket Maximum.

G. Prior Authorization.

1. IMPORTANT NOTE: Significance of Prior Authorization. Prior Authorization (or "Preauthorization") for any health care service or procedure means only that the proposed service or procedure is Medically Necessary and appropriate for the diagnosis given. Prior Authorization does not mean that eligibility, payment, or benefits are guaranteed. Payment for any health care service or procedure will be determined on the basis of the plan of benefits in effect at the time the service or procedure is performed, regardless of

any Prior Authorization. The Plan's Prior Authorization service does not certify eligibility or that those services are a covered benefit.

2. Notification. To obtain Prior Authorization for medical care for yourself or a covered Dependent, the Utilization Review Organization listed in the Quick Guide to Important Contacts must be notified. Notification may be made by the patient, the patient's Physician, family member, or other provider of service.

3. Required for Certain Services. Prior Authorization is required for many services and tests (unless otherwise noted, call Nevada Health Solutions at (855) 392-0778). The list of services requiring prior authorization is as follows:

   a. All Hospital admissions. For Emergency Services, Authorization should be sought within one business day after admission. For Hospital admissions related to childbirth, Prior Authorization is required for Hospital stays that last, or are expected to last, longer than 48 hours following a normal delivery, or 96 hours following a cesarean section.

   b. All outpatient surgeries or procedures at an ambulatory surgery center except colonoscopy/sigmoidoscopy.

   c. Certain in office or outpatient freestanding facility services, including:

      (1) all hematology/oncology services,

      (2) hyperbaric treatment

      (3) orthotic and prosthetic appliances over $500, as well as wigs,

      (4) radiology services: CT/CTA, discography, Magnetic Resonance Imaging (MRI), CT/CTA and MRAs (angiography with CT or MRI), PET scans and SPECT scans

      (5) Varicose veins,

      (6) TMJ procedures/orthognathic surgery,

   d. All outpatient hospital surgeries and invasive diagnostic procedures performed in surgery area except colonoscopy/sigmoidoscopy and all physical, speech and occupational therapies performed in an outpatient hospital setting.

   e. Polysomnography (sleep studies).

   f. Home health and home infusion services – all skilled services in a home setting.

   g. Durable medical equipment) (including wheelchairs, oxygen equipment, hospital beds, etc.), if line item charges are $500 or more, whether rented or purchased.

   h. Skilled Nursing Facilities, Acute rehabilitation and long term care (LTAC) facilities.

i. Dialysis.

j. Solid Organ Transplants, Bone Marrow Transplants, and Stem Cell Transplants.

k. Air ambulance transport.

l. All clinical trials.

m. Residential Treatment Programs (with MAP Prior Authorization).

n. All genetic testing.

o. Autism Treatment, including Applied Behavioral Analysis (ABA) Therapy.

p. Any biologics or implantable hormone replacement therapy that are administered in a physician's office.

q. Any visit for Short-Term Physical, Occupational, Speech Therapy after 60 visits.

You must follow these requirements to be sure you receive your Maximum Benefits. If you do not receive Prior Authorization when required, your benefit payments will be reduced to payment of 50% of Allowable Expenses for Hospital, surgical, Doctor and miscellaneous charges under the Indemnity Medical Plan. If you are enrolled in the EPO plan for active participants and non-Medicare eligible retirees and do not receive Prior Authorization when required, your benefit payments will be reduced by 100% of Allowable Expenses for Hospital, surgical, Doctor and miscellaneous charges. No benefits will be provided for any days of confinement or services or supplies determined to be not Medically Necessary by the Utilization Review Organization. Benefits will not be reduced for admissions when using a Non-Network Provider in the case of Emergency Medical Conditions; however, Continued Stay Review is required.

4. Elective Admission Out of Area. Elective admissions for outpatient and inpatient services and procedures out of area, meaning outside the geographical area of the Plan (Southern Nevada), require Prior Authorization. Failure to obtain authorization to use an out of area facility will result in payment of 50% of Allowable Expenses by the Plan, whether the services or procedures were Medically Necessary or not.

5. Further Information on Prior Authorization of Hospital Admissions. Prior Authorization for Hospital admission is a program designed to avoid unnecessary hospitalizations. Through this review process, you and your Doctor will be advised if an inpatient Hospital stay is appropriate. A recommended surgery may be able to be performed on an outpatient basis, thus saving you out-of-pocket expense.

a. *Non-Emergency Hospitalizations*. If you are advised of a non-Emergency Services Hospital admission you must tell your Doctor that you are required to receive Prior Authorization. To avoid confusion and delayed payment, you should also call to confirm that your Doctor has received a Prior Authorization. You, your Doctor, the Hospital and the Administrative Office will be advised if the hospitalization is approved. In the event there is disagreement as to whether hospitalization is Medically Necessary, your Doctor and the Doctor from the

review organization will resolve the problem. If it is not resolved, you will be advised at that time and told about the appeals procedure. However, before any expenses are incurred, you will know that your claim may be denied because the hospitalization is not Medically Necessary. This program protects you.

b. *Emergency Hospitalizations*. If it is necessary for an Eligible Individual to be admitted to the Hospital due to an Emergency Medical Condition, it will not be necessary to get Prior Authorization. However, the Plan's review organization will then review the records to determine the necessity of the admission and the required length of stay.

c. *MAP Referral*. Hospitalization resulting from a referral by MAP ("Member Assistance Program"). If an Eligible Individual requires hospitalization through a referral by MAP, it is not necessary to obtain Prior Authorization or a Continued Stay Review. All MAP referred hospitalizations will be handled by MAP.

d. *Precertification of Certain Medication.* See Part 8 for more information on drugs needing prior authorization.

H. Case Management (Voluntary/Mandatory).

1. Case Management Review. Diagnosis, utilization, care and treatment may be reviewed to determine whether necessary, appropriate, effective, and/or efficient care is being provided, utilized or accessed. For example, a patient's needs may be met as well or better by offering an alternative to an acute care Hospital confinement. Such alternatives could include home, Hospice, or skilled nursing facility care. In cases involving long-term disabling diseases or frequent readmissions, the Case Management may assist or facilitate the patient's Physician to assess whether different or additional alternative care is appropriate or warranted for the patient. In cases involving prescription narcotic usage, Case Management may suggest or require a single source prescriber or pharmacy, and/or substance use disorder counseling or treatment. In some cases, determined in the sole discretion of the Plan, Case Management may be optional or voluntary. However, in other cases, also determined in the sole discretion of the Plan, Case Management may be mandatory and required in order for the Participant or Dependent to remain eligible for full plan benefits.

2. Case Management in General. The Plan has the full and complete authority and discretion to require or mandate Case Management, the terms and conditions thereof and full compliance therewith. Case management means medical or other healthcare services to inform, educate, and assist patients, their healthcare providers, and the Plan, and to facilitate or prescribe proper, effective and efficient care, including identifying and facilitating additional medical resources, services, or other healthcare and treatments, expanding and providing information about treatment options, and facilitating and coordinating activities and full and timely communications among health care providers and other professionals. Circumstances for Case Management include, but are not limited to, Chronic illnesses, acute catastrophic injury, infectious diseases, burns, terminal illness, transplants, major surgery, Prescription Drugs (for example, narcotics or other controlled substances), addictions, high risk pregnancies, neonatal complications, among others. Mandatory Case Management also can include required independent medical

examinations and evaluations, referrals and participation in member assistance programs (MAP), or other specialty programs or providers, among others.

3. Case Management for Narcotics. In Mandatory Case Management cases involving narcotics, the Plan, in its sole discretion, may require among other things:

   a. Prior Authorization for all narcotics;

   b. Filling all narcotic prescriptions only through a specified pharmacy;

   c. Narcotic prescriptions prescribed only by a specified Physician;

   d. Narcotic prescriptions at retail only, and only a 30 day supply;

   e. Independent medical exams paid for by the Trust;

   f. Reduction of benefits and/or suspension of eligibility for failure to fully cooperate and timely comply;

   g. Certain specified benefits/treatments covered to enable/facilitate compliance with Case Management requirements; and/or

   h. Elimination of Prescription Drug coverage for narcotics in the sole and absolute discretion of the Plan;

   i. Any variation of the above.

   The foregoing list is illustrative and not exclusive of the requirements the Plan may prescribe.

4. Failure to Cooperate. If the covered person for whom Case Management is mandated, and, in the case of a dependent, the parent(s) of legal guardian(s) of the covered dependent, or his or her treating health care providers, including Physicians, fail or refuse to fully, faithfully and timely cooperate with and participate in Case Management when mandated, as determined in the sole discretion of the Plan, plan benefits, including but not limited to medical, Prescription Drug and dental benefits, for that covered person may be reduced up to and including 100% and/or the eligibility of that patient suspended entirely, until full cooperation and compliance is shown to the satisfaction of the Plan.

I. Ensuring Your Level of Care.

1. Mandatory Inpatient Care from Hospitalist Program Physician. If a Participant is admitted as an inpatient at a Hospital at which a Hospitalist Program exists, he or she is subject to the Hospitalist Program.

   a. Inpatient care by the Hospitalist Program Physicians is required for all Participants. This is inpatient care by primary care Physicians only. Primary care Physicians are general practice, family practice and internal medicine Physicians. The Hospitalist Program does not include Physician care by specialists such as cardiologists, dermatologists, oncologists or anesthesiologists. For purposes of

the Hospitalist Program only, OB/GYN and pediatric Physicians are considered specialists, not primary care Physicians.

For inpatient Physician primary care under the Hospitalist Program, the Plan will pay the full Allowable Expense including any Copays, Coinsurance and Deductibles. The Participant will not have any out-of-pocket expenses for covered services by Hospitalist Program Physicians. Care by specialists will continue to be covered and paid as normal under the Plan rules. This rule does not apply outside the Las Vegas Hospital service area.

b. If the Participant refuses care from the Hospitalist Program Physician and instead accepts inpatient Hospital care from his or her own primary care Physician (not including OB/GYN and pediatric Physicians) or any other nonspecialist Hospital-based Physician outside of the Hospitalist Program, the Plan will pay nothing for such care, and the Participant will be solely responsible for all amounts billed by such primary care Physician.

c. A Participant who has been admitted and is receiving care from a Hospitalist Program Physician also may accept care from his or her pre-established primary care Physician who has been actively involved in his or her ongoing primary care. However, his or her pre-established primary care Physician providing care to an admitted Participant will be reimbursed by the Plan for a consultation only and will not be the manager of the Participant's inpatient care.

2. Voluntary Hospitalist Services. If a Participant is not required to participate in the Hospitalist Program, during a hospitalization in a local Hospital, an Eligible Individual may request a Doctor to act as a Hospitalist to oversee and coordinate care provided during the Hospital stay. A Hospitalist can be available to follow up on laboratory results and nursing staff, answer questions you or family members may have about your care, and coordinate with your other Doctors. Voluntary Hospitalist services are not available (a) in the case of an admission for childbirth, for which the OB/GYN will be responsible for coordinating care, or (b) if you request your regular Physician to oversee your care.

J. Pilot Program.

1. A pilot program is an activity or benefit administered by the Plan or its designee, but outside the structured scope of the Plan benefits. The Trustees can use the pilot program structure to test the feasibility and impact of health care initiatives, alternative benefit structures, education programs, and health care delivery models for a limited timeframe and at a limited cost to the Plan. The purpose of a pilot program is to operate, test, and evaluate program impact prior to implementing a permanent Plan change.

2. Pilot programs may be developed and executed for all or only a specific portion or subset of the Employees and Dependents under the guidelines approved by the Trustees or their designee.

3. A pilot program may impact other Plan benefits not related to the pilot. Participation in a pilot program is voluntary. Pilot program administrators may offer alternate treatment, benefits, or education programs than those covered under the Plan. The Trustees, at their discretion, may approve coverage for these alternatives, even if they would not

ordinarily be covered by the Plan. However, in all cases, the decision to access these alternatives by participating in the pilot program rests with the Eligible Individual. The Trustees reserve the right to make the final determination as to whether an Employee or Dependent is eligible for participation in a pilot program.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 7. MEDICAL BENEFITS.

The Quick Guide to Benefits provides a summary of the most common benefits under the Indemnity Medical Plan and the EPO Plan. Important additional information is included below.

A. Hospital Expenses.

1. Inpatient Hospital Room and Board. Hospital charges for semiprivate room and board. For private accommodations in a Hospital for a reason other than the isolation of the patient because of the patient's communicable diseases, the eligible expenses for room and board are subject to a daily limit equal to the Hospital's standard semiprivate room rate. If the Hospital does not have semi-private rooms, the limit is 80% of the daily charge for its lowest rate private room. Confinement in an intensive care, cardiac care or neonatal unit is payable in place of the room and board expenses described in this paragraph.

2. Other Inpatient Hospital Services. Hospital charges for other services and supplies furnished by the Hospital for medical care such as operating room, medicines, Drugs, anesthesia, x-ray examinations, treatment with x-ray, radium and other radioactive substances, laboratory tests, surgical dressings and supplies, etc., but not professional services.

   It will be necessary for you to submit satisfactory proof of each charge used to satisfy the Deductible and each charge for which benefits are being claimed. Therefore, we urge you to keep an accurate record of each covered individual's medical expenses, as this will be of considerable assistance in the completion of the claim forms.

3. Skilled Nursing Facility Services. Room, board and other services approved and determined as Medically Necessary by the Utilization Review Organization through Prior Authorization. Room and board charges are limited to the Allowable Expenses for Network Providers. The Maximum Benefit is 60 days per Calendar Year for the Indemnity Medical plan and 100 days per calendar year for the EPO plan with respect to Network Providers. If the patient is transferred directly from a Hospital to the skilled nursing facility, the per Hospital admission Deductible (for the Indemnity Medical Plan) or the per day copayment (for the EPO Plan) is credited toward the Skilled nursing facility Deductible. There is no plan coverage for Non-Network Provider Skilled Nursing Facility Services.

4. Outpatient Emergency Room Services. Covered Expenses for Emergency Services shall include charges for the facility and professional services in an emergency room, and charges for treatment received in a Network Provider Urgent Care Facility. The Maximum Benefit for Medically Necessary, but non-Emergency Services received in an emergency room is $75 per visit under the Indemnity Medical plan; there is no benefit for non-Emergency Services received in an emergency room under the EPO plan. If you do not have an Emergency Medical Condition, you should consider using an in-network Urgent Care Facility for a lower Copay.

5. Outpatient Surgical Facility Services. If you or your Dependent undergoes surgery in an outpatient department of a Hospital, a Surgical Center, a Doctor's office, or an approved Outpatient Surgical Facility, the Plan will cover charges incurred for necessary services

and supplies provided by the facility, excluding Home Health Care nursing and Physician fees.

B. Expenses In or Out of the Hospital.

1. Doctors' Services. Expenses for a Doctor's services for conditions due to an Accident or illness including surgery, home, office, Hospital visits, and other medical care and treatment. You also do not need Prior Authorization in order to obtain access to OB/GYN care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PPO network at their website listed on the Quick Guide to Important Contacts.

2. Manipulative Services. Manipulation, chiropractic and related services (except for fractures or dislocations), whether performed by a chiropractor or other health care professional, are subject to a Maximum Benefit of 20 visits per Calendar Year, in or out of network under the Indemnity Medical plan. For non-Medicare eligible participant in the EPO plan, benefits are subject to a maximum of 20 visits in a calendar year for in-network providers. For Medicare-eligible participants in the EPO plan, there is no limit visit for in-network providers. There is no benefit for out-of-network providers.

3. Nursing Care. Nursing provided by a Registered Nurse, licensed vocational Nurse, or licensed practical Nurse if specified as Medically Necessary by the attending Physician.

4. Physiotherapy. Treatment by a qualified physiotherapist to restore or rehabilitate any physical loss or impairment caused by injury or sickness; subject to the maximum short-term rehabilitative services benefit of 60 calendar days of treatment for each injury or sickness per year for the Indemnity Medical plan. There is no limit for Medicare-eligible retirees in the EPO plan.

5. Second or Third Surgical Opinion. The Plan will pay charges for a second surgical opinion if the following conditions are met:

   a. Allowable expenses for the second opinion are limited to the examination and consultation;

   b. The second opinion is from a specialist in the appropriate field of surgery;

   c. The second opinion surgeon must not be a part of the same medical or surgical group as the surgeon who is performing the surgery;

   d. The patient and the second opinion Physician must complete the appropriate claim form, if required by the Plan;

   e. If the second opinion differs from the first opinion, a third opinion may be obtained following the above guidelines.

6. Short-Term Physical, Occupational, Speech Therapy Services. The Plan will pay for outpatient short term physical, occupational, speech therapy services with Network or Non-Network Providers. Inpatient admission is payable only if services are provided by a Network Provider rehabilitation facility. However, all short-term physical, occupational, speech therapy services have a combined inpatient and outpatient Maximum Benefit of 90 visits per calendar year. *Prior authorization is required after 60 visits.* There is no limit for Medicare-eligible retirees in the EPO plan.

7. Temporomandibular Joint Treatment. Treatment of the temporomandibular joint (TMJ) that is Medically Necessary, excluding those methods of treatment that are recognized as dental procedures. Dental procedures include, but are not limited to, the extraction of teeth and the application of orthodontic devices (braces). The benefit is paid at 50% of Allowable Expenses up to the Maximum Benefit payable for TMJ services of $2,500 in a Calendar Year and up to a lifetime maximum of $4,000 for Network Providers and Non-Network Providers. Maximum Benefit for TMJ Treatment applies no matter what form of treatment, including surgery, prosthesis or any other form of treatment, is received.

8. Routine Costs for Clinical Trials.

   a. Coverage. If you are a Qualified Individual and participate in an Approved Clinical Trial, the Plan will not deny (or limit or impose additional conditions on) the coverage of Routine Costs for items and services furnished in connection with your participation in the trial. The Plan will not discriminate against you based on your participation in the Approved Clinical Trial. Covered services available for the clinical trial or study must be provided by a PPO Provider.

   b. Definitions.

      (1) A "*Qualified Individual*" is a Participant who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a PPO Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

      (2) An "*Approved Clinical Trial*" is 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, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.

      (3) "*Routine Costs*" are routine patient costs including items and services consistent with the Plan's coverage for an individual who is not enrolled in a clinical trial. Routine 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.

(4) Contact Information. For questions about the coverage for Approved Clinical Trials, please contact the Administrative Office or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789.

C. Expenses Outside the Hospital.

1. Ambulance Services. Ground ambulance service for local travel to or from a Hospital if Medically Necessary. Ground ambulance is subject to a Copayment. The Copayment is in addition to any Copayment for air ambulance. Air ambulance is subject to a Copayment, and covered by the Plan up to the Allowable Expense, when Medically Necessary and appropriate due to the severity of the patient's condition and certified as necessary by the attending Physician.

2. Anesthesia. Cost of anesthetics and their administration.

3. Autism Treatment Services. Subject to Prior Authorization, the Plan will pay 100% of Allowable Expenses after a $20 copayment per visit ($25 copayment for visit for those enrolled in the EPO Plan) for autism treatment services, including Applied Behavioral Analysis (ABA) therapy, for PPO Providers, with a $72,000 calendar year maximum for children through age 18 or through age 22, if still enrolled in high school. Prior authorization is required for all services and must be obtained every 6 months. Treatment must be identified in a treatment plan that is prescribed by a licensed physician or licensed psychologist and provided by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst. There is no Plan coverage for any autism services that are not preauthorized or are provided by a Non-PPO Provider.

4. Dental and Oral Surgical Services. The following services are covered under the Indemnity Medical Plan:

   a. treatment for Accidental injuries to natural and sound teeth, crowned teeth, the jawbones, or surrounding tissues;

   b. the correction of a nondental, physiological condition that has resulted in a severe functional impairment; and

   c. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

   The medical benefits Deductible does not apply to such services when provided by a Network Provider.

5. Diabetes Education. For individuals initially diagnosed with diabetes, classes for diabetes management, reviewing types of diabetes, eating habits, blood sugar

management and testing, and medication management. Classes are available at any Network Provider Hospital. Additionally, individuals diagnosed with diabetes may consult with an in-network nutritionist for nutritional counseling 3 times per year. This benefit is covered 100% when Medically Necessary.

6. Diagnostic Radiology. Routine radiological and non-radiological diagnostic imaging and testing. Certain tests must be preauthorized to ensure the greatest benefit.

7. Diagnostic and Therapeutic Services:

   a. Chemotherapy.

   b. X-ray and radium treatments and treatments with other radioactive substances.

   c. Allergy testing and serum injections.

   d. Otologic evaluations.

   e. Complex psychological diagnostic testing.

   f. Amniocentesis that meets the guidelines of the American College of Obstetrics and Gynecology.

   g. Other complex diagnostic and therapeutic services, such as diagnostic imaging, pulmonary diagnostic services, etc.

   h. Hyperbaric treatment will be covered, subject to the specialist/consultant Network Provider Copayment or Non-Network Provider Calendar Year Deductible and Coinsurance. An additional $25 facility Copayment per treatment will apply for each of the first four (4) treatments by Network Providers and 50% of Allowable Expenses per treatment by Non-Network Providers.

8. Bariatric Surgery. In the Indemnity Medical Plan, outpatient bariatric surgery is covered at 100% above a $1,000 Copayment and inpatient bariatric surgery is covered 100% after a $2,500 Copayment. In the EPO Plan, outpatient bariatric surgery is covered at 100% after a $1,500 Copayment and inpatient bariatric surgery is covered 100% after a $1,500 Copayment for Non-Medicare eligible retirees; for Medicare-eligible retirees there are no copayments. There is no benefit if the surgery is not performed by the Plan's designated bariatric surgeons.

   a. This benefit does not apply if you had bariatric surgery in the past covered by the Plan. This benefit is limited to one (1) per lifetime.

   b. Bariatric surgery must be recommended by your primary care provider for the treatment of morbid obesity. It must be Medically Necessary and Preauthorized by the Plan's Utilization Review Organization. The bariatric surgery must also be performed by one of the Plan's designated bariatric surgeons.

   c. You must meet all the following criteria to be eligible for the coverage:

(1) You are currently eligible under the Plan at the time of the surgery;

(2) You have been an eligible Participant under this Plan for at least 60 months of the previous seven (7) years and must have been eligible for coverage for at least six (6) months during the 12 months prior to the surgery;

(3) You fully and cooperatively attend the pre-operative seminar offered by the Plan's designated bariatric surgeons;

(4) You comply with Prescription Drug benefit guidelines, use of generic and formulary medications wherever possible;

(5) You actively participate in diet programs prior to Plan approval, including, but not limited to weekly consultations with an in-network nutritionist (which will be covered by the Plan subject to the appropriate copayment);

(6) You have not previously undergone bariatric surgery covered by this Plan; and

(7) You complete all required preoperative screening tests, and based on the results, qualify for weight loss surgery. Preoperative screening tests to include a psychological evaluation by a licensed psychologist, psychiatrist or other mental health professional experienced in weight loss surgery.

d. Coverage for Cosmetic Surgery for the removal of excess skin, face or body lifts after bariatric surgery is excluded from the plan.

e. Non-Spouse Dependents are not eligible for bariatric surgery.

9. Dialysis Treatment. Dialysis outpatient services and supplies.

10. Hearing Examinations and Hearing Aids. Charges for (1) a hearing examination performed by a licensed Physician or a licensed or certified audiologist; and (2) hearing aid devices ordered by them, up to a maximum payment of $500 per ear, in any three (3)-year period. A hearing aid is only covered after the examining Physician has certified that the Employee or covered Dependent is suffering from hearing loss that may be lessened by use of the device.

11. Home Health Care. Home Health Care and supportive services that would have been covered under the Plan if the services had been performed in a Hospital or convalescent Hospital, subject to the following provisions:

a. The services must be prescribed by a Doctor to be performed in the covered person's home;

b. The services must be prescribed as Medically Necessary for the care and treatment of illness or injury and authorized by the Utilization Review Organization;

c. The services must be performed by or under the supervision of a person who is licensed, certified or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a Hospital or convalescent Hospital; and

d. The benefits payable for such services will not exceed the amount that would have been payable had the services been performed in a Hospital or convalescent Hospital.

12. Hospice Care Services.

a. Hospice care services are payable under the Plan if the services are provided through a Hospice Care Program that—

(1) meets the standards of the National Hospice Organization; or if required by a state, is licensed, registered or certified by that state as a Hospice Care Program; and

(2) is in association with the patient's final illness when a Doctor determines there is no hope for a cure and the patient has six (6) months or less to live.

b. This benefit will then pay for—

(1) Inpatient care while confined in a Hospice; room and board charges limited to the most common daily charge for a semiprivate room by an affiliated Hospital or nursing home, or the Allowable Expenses. A $600 Non-Network Provider Deductible apply to Hospice admission under the Indemnity Medical Plan; there is no copayment for Network Providers under the Indemnity Medical Plan, or under the EPO Plan. If the patient is transferred directly from a Hospital to a Hospice, the Hospital admission Deductible is credited toward the Hospice admission Deductible;

(2) Outpatient Hospice services;

(3) Inpatient respite services;

(4) Outpatient respite; and

(5) Bereavement counseling services by Hospice care team members for Participants within the family. Treatment must be completed within six (6) months of the date of death.

13. Laboratory services. Laboratory exams and tests that are a result of an illness or Accidental injury and requested by a Physician.

14. Major Organ and Tissue Transplant Benefit. The Plan will pay benefits for covered major organ transplant expenses that are incurred by a covered person for an approved transplant.

a. Major organ transplant means pretransplant, transplant and post-discharge services, supplies, care and treatment received in connection with the Medically Necessary transplantation of human organs or tissue.

b. A major transplant procedure must be approved in advance by the Utilization Review Organization. Approval of a procedure will be based on established written criteria and procedures. Unless Prior Authorization is given, benefits will not be provided.

c. For a list of PPO transplant facilities, contact the Transplant Provider.

15. Medical Supplies, Prosthesis, Orthotics and Durable Medical Equipment. Blood and blood products; artificial limbs, eyes and larynx; surgical dressings; casts; splints; trusses; braces; crutches, rental or purchase, whichever is determined by the Administrator to be most cost effective of the Plan, for wheelchair, Hospital bed, or ventilator, oxygen and rental equipment for its administration.

16. Orthotics and Prosthetics. Under the Indemnity Medical Plan, prosthetics and orthotics that are an integral part of a brace are subject to a Network Provider $50 Copay per device. In addition, Non-Network Provider benefits are limited to 50% of Allowable Expenses.

When orthotics are not an integral part of a brace, the Plan covers 100% of the first $500 of Allowable Expenses for Network Provider benefits, after which you are responsible for 90% of Allowable Expenses. In addition, Non-Network Provider benefits are limited to 50% of Allowable Expenses up to the first $l,000 of Allowable Expenses (i.e. the Plan pays up to $500 of the first $1,000 of expenses, and you would pay the other $500) after which you are responsible for 90% of Allowable Expenses.

Under the EPO Plan, prosthetics and orthotics provided by an in-network provider are covered at 100% after a $750 copay per device, subject to a lifetime maximum benefit of $10,000 for active participants and non-Medicare eligible retirees. For Medicare-eligible retirees, the participant pays 20% coinsurance.

Under both the Indemnity Medical Plan and the EPO Plan, the Plan covers expenses for wigs (cranial or scalp prosthesis) up to $300 every 2 years for baldness related to the following medical conditions or treatments: chemotherapy, radiation treatment, severe burns with resulting permanent alopecia, alopecia totalis, alopecia areata or alopecia universalis. Coverage is not provided for baldness or hair loss due to natural aging, premature balding, or male or female pattern baldness. Coverage is subject to Prior Authorization.

17. Preadmission Testing. Medically Necessary laboratory and x-ray examinations performed on an outpatient basis prior to admission for surgery if the Hospital charges for the inpatient services are covered under the Plan. In order to qualify as a covered expense, the subsequent hospitalization or surgery must occur within seven (7) days of preadmission testing, or within 30 days if postponement was Medically Necessary.

18. Genetic Testing and Counseling. Genetic testing involves 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. The following medically necessary genetic testing is payable under this Plan (in accordance with how other covered laboratory services are payable under the Plan):

(a) state-mandated newborn screening tests for genetic disorders;

(b) fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee;

(c) tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity;

(d) genetic testing recommended by the American College of Obstetrics and Gynecology (ACOG) for pregnant women such as genetic carrier testing for cystic fibrosis;

(e) genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see also the Preventive Care services outlined in this Part 7.

(f) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if all the following conditions are met:

a. the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

b. the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and

c. the results of the test will directly impact clinical decision-making, outcome or treatment being delivered to the covered individual.

(g) diagnostic genetic testing used to identify or rule out a specific genetic or chromosomal condition when a particular condition or diagnosis for a patient is suspected based on physical signs and symptoms.

Genetic Counseling refers to services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and counseling provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision. Genetic Counseling is payable when

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

Plan participants may use the Plan's Prior Authorization procedure (by contacting the Utilization Review Organization) to assist in determining if a proposed genetic test will be considered as covered or excluded by the Plan. See also Section J on What is Not Covered? for information on genetic services not payable by the Plan.

19. Preventive Care. Preventive Care benefits, shall include

a. Office visits (including smoking cessation office visits), laboratory and diagnostic services (such as EKGS).

b. Physical examinations.

c. Well-child care.

d. Gynecological exams.

e. Pap smears.

f. Radiology services (such as mammograms, DEXA scans).

g. Services rated "A" or "B" by the U.S. Preventive Services Task Force.

h. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, including no charge for these immunizations when obtained at a network retail pharmacy location.

i. Preventive care and screenings for women and children as recommended by the Health Resources and Services Administration.

j. FDA-approved female sterilization services (e.g., tubal ligation, implants such as Essure).

k. FDA-approved contraceptive management, including contraceptive methods and counseling for females.

l. Prenatal visits.

m. Well-woman visits.

n. Breastfeeding pump and supplies and lactation counseling by a certified consultant. For the duration of breastfeeding, coverage is provided for lactation support and counseling, a standard manual or standard electric breast pump, plus necessary breast pump supplies. Rental is payable up to the allowed purchase price of the breastfeeding pump. Repair, adjustment or servicing of a breastfeeding pump is payable. Replacement of a breastfeeding pump is payable only if there is a change in the Covered Person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense.

o. Additional preventive care benefits required by Health Care Reform regulations, such a screening for gestational diabetes, HPV testing, HIV screening, screening and counseling for interpersonal and domestic violence, coverage for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, BRCA testing and counseling for women with family histories of breast, ovarian, tubal, or peritoneal cancer or for women with a prior non-BRCA related breast cancer or ovarian cancer diagnosis, preventive care services related to pregnancy for dependent children when an attending provider determines the services are age and developmentally appropriate for the dependent, and anesthesia associated with colonoscopies if the attending provider determines it is medically appropriate.

p. Over-the-counter drugs in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations obtained through the Outpatient Prescription Drug program at a participating network retail pharmacy.

q. Cologuard. At-home colon cancer screening as prescribed for participants once every 12 months.

20. Telehealth and Videoconferencing Services. Telehealth and videoconferencing services for all providers that offer distance medicine services, including, but not limited to, telehealth and videoconferencing services for all primary care office visits and specialists office visits.

Preventive Care Benefits will be covered at 100% of Allowable Expenses for Network Providers. Under the Indemnity Medical Plan only, non-Network Providers are covered at 50% of Allowable Expenses and subject to the Non-Network Provider $500 Calendar Year Deductible; provided that Preventive Care Benefits provided by a Non-PPO Provider will be covered at 100% of Allowable Expenses if, and only if, the particular item or service provided by the Non-PPO Provider is not available from a PPO Provider.

For a list of additional covered preventive care benefits required by Health Care Reform regulations, please contact the Plan's Administrator. In the absence of specific guidance in a Preventive Service guideline or recommendation, the Plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive service.

D. Behavioral Health Service Benefits.

1. How Do Behavioral Health Service Benefits Work?

a. The Plan has implemented a Member Assistance Program (MAP). These services are provided through the Member Assistance Program administrator listed in the Quick Guide to Important Contacts.

b. MAP is a program dedicated to providing confidential and professional counseling for Employees and their Eligible Dependents in the event of personal crises. Through MAP, professional counselors will provide assistance for issues such as:

- Marital
- Family
- Children
- Anger Management
- Alcohol Use Disorder (Personal or Family)
- Other Personal or Emotional Problems
- Drug Use Disorder (Personal or Family)

Trained MAP professionals are available 24 hours a day, 7 days a week, to help identify and evaluate the patient and provide treatment or, if necessary, refer the patient to an appropriate resource for help. In order to receive benefits, the patient must contact the Utilization Review Organization for Mental Health and Substance Use Disorder benefits) listed in the Quick Guide to Important Contacts prior to receiving inpatient treatment. In the event of hospitalization for an Emergency Medical Condition, benefits will be paid only if the patient contacts the Utilization Review Organization within 72 hours. If the Participant does not notify the Utilization Review Organization of an inpatient admission or uses an in-patient Non-Network Provider, benefits will be reduced to payment of 50% of Allowable Expenses. If the Participant does not notify the Utilization Review Organization of an inpatient admission **AND** uses an in-patient Non-Network Provider, benefits will be reduced to payment of 25% of Allowable Expenses. Participants in the EPO plan will receive no benefits for any services provided by a Non-Network Provider.

There is no cost to you or your family members for this service for the first six (6) visits. There is no cost to call the Utilization Review Organization in the face of crises, to talk to Utilization Review Organization about the issue you are facing, to find out what options there are or to understand what benefits you qualify for. If you then decide to seek counseling or treatment, there may be some cost for continuing help.

For assistance, call the Utilization Review Organization for Mental Health and Substance Use Disorder benefits the phone number provided in the Quick Guide to Important Contacts.

2. What Benefits Are Provided?

a. *Benefits Provided*. The MAP Provider offers a full range of Behavioral Health Services, as well as other benefits. The core MAP services include:

- Up to 6 in-person counseling sessions per unique presenting problem, per twelve month period, per Participant. In-person counseling sessions shall be per unique presenting problem for issues or concerns directly impacting the Participant. In-person Counseling services are provided when the MAP assessment reveals that the presenting problem has a reasonable and likely chance of improving as a result of short-term in-person counseling that is focused on problem resolution.

- Referral to appropriate healthcare benefit and/or clinical resources in the community in situations where the Participant's presenting problem warrants long-term treatment, hospitalization or a more specialized level of care.

- 24 hours per day/ 7 days per week/ 365 days per year toll-free telephone access to a mental health clinician.

- Legal Referrals & Discounted Fees: One free 30-minute telephone or in-person consultation with a licensed attorney.

- Financial Consultation: Unlimited telephone consultations with an appropriate Financial Consultant.

- Identity Monitoring and Theft Recovery: Credit monitoring and telephone consultation to help recovery from and minimize the impact of a breach of identity.

- Tobacco Cessation: online educational tools and telephone consultation with a tobacco cessation coach, unlimited access to the MAP website for information and referral.

- Work/Life Resources and Information: Consultations, educational materials and referrals regarding child care, adult dependent care, elder care, adoption, or parenting. Unlimited access to web-based information and resources about child care, adult dependent care, elder care, adoption, and parenting.

The mental health benefits summarized in the Quick Guide to Benefits will be payable for approved emotional or chemical dependency problems. Benefits will be reduced to payment of 50% of Allowable Expenses for use of Non-Network Provider services under the Indemnity Medical Plan. There is a $100 Deductible per person for inpatient hospitalization under the Indemnity Medical Plan and a $300 per day copayment up to a maximum of $900 under the EPO plan for active participants and non-Medicare eligible retirees; there is no copayment for Medicare-eligible retirees. The inpatient benefit includes acute, subacute and partial hospitalization (day care) services.

3. What Benefits Are Limited or Not Provided? Services or treatment will not be provided for the following conditions and under the following circumstances:

If a Participant does not obtain Preauthorization from Utilization Review Organization for Mental Health and Substance Use Disorder benefits listed in the Quick Guide to Important Contacts for inpatient treatment or the following outpatient treatment, benefits for in-network services will be reduced to payment of 50% of Allowable Expenses:

Partial Hospitalization Programs
Chemical Dependency or Psychiatric Intensive Outpatient Programs

a. Mental retardation, other than to make a primary diagnosis.

b. Conditions of a Participant for which there is no reasonable hope of improvement as determined by the clinical management committee.

c. Chronic schizophrenia.

d. Children performing poorly in school without exhibiting a diagnosed behavioral health condition. Tutoring and educational therapy is covered only as an adjunct to required therapy when inpatient treatment is authorized.

e. Services or treatment paid for by another health plan or other group insurance, as described in Part 12.A.

f. Services or treatment provided as a result of any workers' compensation law, or similar legislation, or obtained through or required by any government agency or program whether Federal, State, or any subdivision thereof.

g. Psychotherapy used as professional training.

h. Chronic physical health problems that have also produced psychological problems. Services are limited to mental health/substance abuse consulting inpatient and outpatient services only.

i. Residential Treatment Programs, Group Homes, Halfway House facilities and services are not covered when provided by Non-Network facilities or providers.

j. Systemic or medical conditions that on their own, regardless of psychiatric diagnosis, would necessitate hospitalization.

k. Eating disorder treatment, gambling disorder treatment and stress management rehabilitation are not covered benefits in an acute-care Hospital. Treatment can be provided in a subacute facility or outpatient setting.

l. Court ordered treatment may not be a covered benefit unless the Plan determines that treatment is both Medically Necessary and a covered benefit.

E. Exclusions and Limitations

1. General Exclusions. The Plan does not cover expenses due to—

a. Services or supplies, including tests and check-up exams that are not needed for medical care of a diagnosed sickness or injury (except covered Preventive Care). To be considered "needed," a service or supply must meet all of these tests: (1) it is ordered by a Doctor; (2) it is commonly and customarily recognized throughout the Doctor's profession as appropriate in the treatment and diagnosis of the sickness or injury; (3) it is not educational or Experimental in nature. For the purpose of this Plan, investigational procedures are considered Experimental; (4) it is not furnished mainly for the purpose of medical or other research.

b. In the case of Hospital confinement, the length of the confinement and Hospital services and supplies will be considered "needed" only to the extent that they are determined to be—

(1) related to the treatment of the sickness or injury; and

(2) not allocable to the scholastic education or vocational training of the patient.

c. Expenses applied toward satisfaction of any Deductibles or Copayments as previously described.

2. Specific Exclusions. The Plan also does not cover—

a. Services for Chronic, intractable pain by a pain control center or under a pain control program or acupuncture or acupressure.

b. Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy, or electronarcosis.

c. Ecological, environmental medicine, vitamin injections, supplements and herbs. Use of chelation or chelation therapy, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for such treatment; electrodiagnosis; Hahnemannian dilution dental fillings; laetrile; or gerovital.

d. Special formulas, food supplements or special diets.

e. Any services or supplies received by a transplant donor related to the transplant and costs related to cadaver organ or tissue retrieval or maintenance of a donor for organ or tissue retrieval, except for those conditions as outlined under Major Organ and Tissue Transplant Benefits. For Eligible Individuals who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.

f. Any expenses incurred for treatment of mental health, alcohol or drug abuse are covered only through MAP as described and limited in Part 7.D.

g. Hospital nursery charges related to routine well-baby care, except that well baby Hospital nursery charges will be covered at any PPO Hospital, including out-of-area PPO Hospitals, subject to the Network Provider benefit schedule. Benefits will be provided in accordance with the Newborns and Mothers Health Protection Act.

h. Prescription and over-the-counter Drugs, except as otherwise provided herein. Drugs and medicines to the extent that they are administered for purposes other than those approved by the Federal Food and Drug Administration (FDA) regardless of whether obtained in the United States or elsewhere. Drugs and medicines approved by the FDA for Experimental or investigational use. Drugs purchased out of the country.

i. Hearing aids: in no event will benefits be paid for: (1) replacement of a hearing aid for any reason more than once in a three (3)-year period; (2) batteries or ancillary equipment other than that obtained upon purchase of the hearing aid;

(3) expenses incurred that the individual is not required to pay; or (4) repairs, servicing or alterations of the hearing aid.

j. Vision examinations to determine refractive errors of vision and eye glasses or contact lenses, of any type except initial pair of eyeglasses or contact lens to replace the loss of the natural lens; refractive keratoplasty procedures including but not limited to LASIK and radial keratotomy; visual therapy (orthoptics).

k. Except as otherwise provided under Dental/Oral Surgical Services, dental splints, dental prosthesis, or any treatment on or to the teeth, gums, or jaws, and other services customarily provided by a Dentist. Charges or services in connection with temporomandibular joint dysfunction are not covered unless determined to be Medically Necessary, and not a dental procedure, and are subject to the benefit limitation for such services listed in Part 6.B and the Quick Guide to Benefits.

l. Hospital expenses incurred for dental treatment, unless Medically Necessary.

m. Expenses payable under the dental expense benefit and Prescription Drug benefit.

n. Expenses incurred for treatment for infertility that involves either a covered person or surrogate as a donor or a recipient, including artificial insemination, embryo transplants, in vitro fertilization, and low tubal transfers.

o. Charges for family planning counseling, including genetic, sterility, and birth control counseling, although prescription contraceptive management and Drugs such as Depo Provera and certain implantable contraceptives and female sterilization services are covered by the Indemnity Medical Plan and certain other prescription contraceptives such as birth control pills are covered Prescription Drugs.

p. Any expense incurred in connection with reversal of an elective procedure, including but not limited to, reversal of a previous vasectomy or tubal ligation.

q. Elective abortions.

r. Any expense incurred relative to gender affirming care, including, but not limited to, gender transition surgery, or any resulting medical complications.

s. Penile prosthesis, unless determined to be Medically Necessary by the Plan.

t. Treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations, (b) corns, calluses or toenails, except removing nail roots and foot care prescribed by an M.D. or D.O. due to treating metabolic or peripheral-vascular disease.

u. Sports medicine treatment plans that are intended primarily to enhance athletic functions.

v. Cosmetic Surgery, not including the following procedures: reconstructive surgery, including Prosthetic devices and treatment for physical complications of

a mastectomy including lymphedemas, following a mastectomy or reconstructive surgery that is a result of Accidental injury, and corrective surgery for newborns who are born with congenital defects and birth abnormalities.

w. Weight loss reduction, control or management; weight loss treatment, regardless of associated medical or psychological conditions; surgical or invasive treatment or reversal thereof for reduction of weight regardless of associated medical or psychological conditions, including treatment of the complications resulting from surgical treatment of obesity, except as otherwise provided under the Plan's bariatric surgery benefits for the treatment of morbid obesity. Morbid obesity means the person is 100 pounds or more over the medically desired weight or having a Body Mass Index (BMI) of 40 or greater.

x. Even if they are required because of an injury, illness or disability, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, applied behavior analysis therapy, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices. The Plan does cover diabetes education for individual newly diagnosed with diabetes.

y. Any equipment or supplies that are primarily nonmedical equipment or supplies.

z. Charges made by a surgeon for visits on the same day he performs a surgical procedure, or during the postoperative period, except as permitted by the approved guidelines.

aa. Charges for services rendered by a person who is an immediate family member of the patient, meaning a spouse, parent, sibling, child or grandparent.

bb. Personal comfort, hygiene, or convenience items such as a Hospital television, telephone, private room (except as Medically Necessary); housekeeping, homemaker, or meal services as part of Home Health Care; modifications and alteration in a home or place of residence, including equipment to accommodate a physical disability, such as elevators, electric chair lifts, hot tubs or home spas, even if prescribed by a Physician, or modifications to a vehicle (electric lifts, etc.).

cc. Services or expenses that cannot reasonably be expected to lessen the patient's disability and to enable him to live outside of an institution.

dd. Institutional care that, as determined by the Utilization Review Organization, is for the primary purpose of controlling or changing the Participant's environment; or custodial care.

ee. Services rendered by any physician not meeting the definition of a Physician.

ff. Services rendered by a hospital not meeting the definition of a Hospital.

gg. Third-party physical examinations for employment, licensing, insurance, school, camp, sports or adoption purposes. Immunizations related to foreign travel. Expenses for medical reports, including presentation and preparation. Examination or treatment ordered by a court or in connection with legal proceedings if not otherwise covered.

hh. The portion of a charge for a service or supply in excess of the Allowable Expenses.

ii. Expense incurred for services and supplies; (1) for which no charge is made, or (2) for which the Participant is not required to pay, or (3) that are paid for or reimbursable by or through a national, state, provincial, county or municipal government or other political subdivision of any instrumentality or agency thereof, except to the extent that such services are reimbursable to the VA for nonservice connected conditions under 38 U.S.C. § 1729.

jj. Any Hospital or medical services covered by the Federal Medicare Program Parts A or B. Any amount payable under the Federal Medicare Program will be subject to the Coordination of Benefits provisions of the Plan.

kk. Work-Related Injuries, Illnesses or Conditions. The Plan does not cover expenses incurred by you or any of your covered Dependents for any injury, illness or condition arising out of or in the course of employment. The Plan may pay claims pending a workers' compensation determination regarding course and scope of employment if the appropriate Repayment Agreement is signed and all the Plan's rules and requirements are followed and satisfied. Refer to Part 13.B (Third Party Recovery Rules).

ll. Any Hospital or medical services in connection with an injury or illness resulting from civil insurrection or war (whether declared or undeclared), rebellion, armed invasion or aggression, or any act incident thereto, participation in a riot, or participation in committing a crime or unlawful act or improper conduct unless the Plan is notified of a health related or other cause that is the source of the injury and is a protected source of injury under applicable federal law (for example, the Health Insurance Portability and Accountability Act or "HIPAA").

mm. Travel, whether or not recommended or prescribed by a Physician or other medical practitioner.

nn. Except in situations in which you have an Emergency Medical Condition, no Plan benefits are payable for any services or supplies, including Prescription Drugs, obtained in a foreign country by or for an eligible Employee or Dependent. To be payable, the eligible Participant must prove the existence of the Emergency Medical Condition to the satisfaction of the Board of Trustees based upon whatever evidence the Board of Trustees may require. If the eligible Participant proves the Emergency Medical Condition to the satisfaction of the

Board of Trustees, benefits will be payable in accordance with the Plan's rules regarding benefits for out-of-area Non-Network Provider Emergency Services for Emergency Medical Conditions.

oo. No benefits shall be paid related to any pregnancy, or complications thereof, where such pregnancy is the result of any financial arrangement, whether denominated as a surrogate or not, whereby the parents of such child receive monetary or other compensation for conceiving and bearing a child for the purpose of placing such child for adoption.

pp. Fees and costs for such things as (including but not limited to):

- Expenses for preparing forms, medical/dental reports/records, bills, disability/sick leave/claim forms and the like;
- Mailing, shipping or handling expenses; or any,
- Charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/membership fees and/or photocopying fees.

qq. Any surcharge fees resulting from state laws (e.g. New York Health Care Reform Act).

rr. Naturopathic, or homeopathic services and substances.

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

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

uu. Expenses for massage therapy, rolfing (deep muscle manipulation and massage) and related services.

vv. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, work hardening and/or weight training services.

ww. Indemnity medical plan including outpatient prescription drug and behavioral health claims, dental plan claims and vision plan claims submitted to the Plan beyond 12 months from the date of service.

xx. Third Party Liabilities. Any expenses caused by any third party, except as provided to individuals who, along with their attorneys, fully comply with the Plan's Third Party Recovery Rules. Refer to Part 13.B (Third Party Recovery Rules).

yy. Genetic Testing and Counseling: Certain genetic tests are covered as listed in Part 6. The genetic services that are not covered by the Plan include:

(1) 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).

(2) 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.

(3) No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the medically necessary treatment of a plan participant.

(4) Home genetic testing kits/services are not covered.

(5) Genetic testing determined by the Plan Administrator or its designee to be not medically necessary, or is determined to be experimental or investigational.

zz. Dsuvia. Expenses related to the pharmaceutical drug Dsuvia.

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.

F. Medical Center Benefits

1. The Plan has established the Teamsters 631 Medical Center, ("Medical Center") for the benefit of all Plan participants and their Eligible Dependents. The Medical Center offers the following services:

a. ***Medical services*** at no cost.

b. ***Diagnostic services*** at no cost. These Diagnostic Services are limited in nature and not all services are available.

c. ***Pharmacy services*** at no cost. The pharmacy services are limited in nature and not all Prescription Drugs will be available.

2. Former Participants (and their formerly eligible Dependents) who are on the out of work list and eligible to be dispatched and who were eligible for plan benefits for at least 6 months in the immediately prior calendar year, may receive services at the Medical Center. The Former Participants and their Dependents may receive services at the Medical Center for only one year following the plan year in which they were eligible for plan benefits for at least 6 months. These Former Participants and their Dependents must pay a $25 access fee, per person, for each date that they receive services at the Medical Center.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 8. PRESCRIPTION DRUGS

A. **General**. Outpatient Prescription Drug Benefits are provided by the Plan through a Prescription Drug Benefit Manager. To find a participating pharmacy, contact or visit the website of the Prescription Drug Benefit Manager that is listed in the Quick Guide to Important Contacts. If you use one of the participating pharmacies, you will not have to file any claim forms or wait for reimbursement.

1. Generics, Preferred Brands and Non-Preferred Brands. When you go to a participating pharmacy you may need to show your Plan identification card. The cost to you when a prescription is filled depends on whether the prescription is a generic Drug, a preferred brand name Drug or a non-preferred brand name Drug.

Indemnity Medical (PPO) Plan Benefits Schedule:

	Copayment			
	Retail (up to a 30-day supply)	**Retail*** (up to a 60-day supply)	**Retail*** (up to a 90-day supply)	**Mail Order** (up to a 90-day supply)
Generic Drugs	$0	$0	$0	$0
Preferred Brand Brand name Drugs on the preferred list	$40	$80	$120	$80
Non-Preferred Brand Brand name Drugs not on the preferred list	$80	$160	$240	$160
Specialty Drug - High-cost, complex Drugs	Not covered	Not covered	Not covered	20% coinsurance up to $200 for up to a 30-day supply

*90-day supply available only at participating CVS Pharmacies

EPO Plan Benefits Schedule for Active Employees and Pre-Medicare Retirees:

	Copayment			
	Retail (up to a 30-day supply)	**Retail*** (up to a 60-day supply)	**Retail*** (up to a 90-day supply)	**Mail Order** (up to a 90-day supply)
Generic Drugs	$0	$0	$0	$0
Preferred Brand Brand name Drugs on the preferred list	$40	$80	$120	$80
Non-Preferred Brand Brand name Drugs not on the preferred list	$80	$160	$240	$160
Specialty Drug - High-cost, complex Drugs	Not covered	Not covered	Not covered	20% coinsurance up to $200 for up to a 30-day supply

*90-day supply available only at participating CVS Pharmacies.

EPO Plan Benefits Schedule for Medicare Retirees:

	Copayment			
	Retail (up to a 30-day supply)	**Retail*** (up to a 60-day supply)	**Retail*** (up to a 90-day supply)	**Mail Order** (up to a 90-day supply)
Generic Drugs Whether or not on the preferred list	$0	$0	$0	$0
Preferred Brand Brand name Drugs on the preferred list	$35	$70	$105	$70
Non-Preferred Brand Brand name Drugs not on the preferred list	$60	$120	$180	$120
Specialty Drug - High-cost, complex Drugs	Not covered	Not covered	Not covered	20% coinsurance up to $200 for up to a 30-day supply

*90-day supply available only at participating CVS Pharmacies

There is a no cost-sharing for formulary diabetic test strips, female contraceptives, and certain over the counter drugs prescribed by a Physician as mandated for coverage in accordance with Health Care Reform. Contact the Prescription Drug Benefit Manager for information on which brands of diabetic test strips are considered formulary.

If you choose the brand-name when a generic is available, you will pay the applicable brand name Copayment, plus the difference in cost between the generic and the brand-name Drug. The amount of the difference in cost between the generic and the brand-name Drug will not count towards your annual Out-of-Pocket Maximum for Essential Health Benefits. Consider saving more money by ordering your prescriptions through the Mail Order Program.

2. Medicare Part D Creditable Coverage. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a

Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare Drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. The Outpatient Prescription Drug Benefits available to you under the Plan is, on average for all Eligible Individuals, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is therefore considered "creditable coverage." Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Drug plan.

If you decide to join a Medicare Drug plan, your current coverage will not be affected. If you do decide to join a Medicare Drug plan and also decide to drop your current coverage under the Plan, be aware that you and your Dependents will be able to get this coverage back. You should also know that if you drop or lose your current coverage under the Plan and do not join a Medicare Drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare Drug plan later.

3. Prior Authorization. Class II and Class III narcotics (after one fill over a rolling 365-day period) and certain Drugs require Prior Authorization from the Prescription Drug Benefit Manager. These Drugs are generally those that have high potential for unnecessary use or have certain risk factors. The list of Drugs that require Prior Authorization is updated from time to time and you should contact the Prescription Drug Benefits Manager if you have any questions about which Drugs are subject to this requirement. If you are taking one of these Drugs, or your Physician prescribes it for you, you will save time by having your Physician call or fax the Prescription Drug Benefit Manager in advance to request Prior Authorization at the numbers listed in the Quick Guide to Important Contacts.

4. Mail Order Program. You can save more money by ordering your maintenance medications through the home-delivery mail order program. Prescriptions may be filled for up to 90 days for most medications, and at a savings to you of up to $80 for brand drugs. To determine your cost savings, you can conduct a price check online or contact the Prescription Drug Benefits Manager as listed in the Quick Guide to Important Contacts. Orders are typically shipped and should arrive within five (5) working days; please allow 10 to 14 working days for your first order. To best use the mail order program, ask your Doctor to write your prescriptions for a 90-day supply with up to one (1) year of refills, if appropriate. Home delivery order forms are available from the Administrative Office or online from the Prescription Drug Benefit Manager.

5. Specialty Drugs. Certain Drugs are only covered if they are provided through the Plan's specialty mail order program Contact the Plan's Prescription Drug Benefit Manager as listed in the Quick Guide to Important Contacts for a list of these Drugs. To obtain these Drugs you will need to join the Plan's specialty Drug program. Your Coinsurance for these Drugs is 20% up to $200 per prescription for up to a 30-day supply. These outpatient Drugs are provided under the Plan's prescription benefits, not its medical plan benefits.

The Variable Copayment Solution program is a procurement program that your plan sponsor has elected to participate in. Not all Specialty medications qualify for this program. Your coinsurance may be waived if you enroll and participate in the Variable

Copayment Solution program. Participation in Variable Copayment Solution is voluntary. Covered medications may still be obtained without participation in the Variable Copayment Solution program (subject to satisfying all other eligibility requirements), but may result in a higher Participant payment amount. Variable Copayment Solution program medications may be discontinued at any time without notice. Contact Plan's Prescription Drug Benefit Manager for more information.

6. Step Therapy. Step therapy is used to discourage the use of high cost Drugs when a less costly alternative with equal effectiveness is available. Under step therapy, you are required to use a "first-line" Drug before authorization is granted for a more costly "second-line" Drug. For a current list of the Drugs that require step therapy, please contact the Prescription Drug Benefit Manager as listed in the Quick Guide to Important Contacts.

7. Non-Network Pharmacy Benefit. If the Employee or Dependent goes to a Non-Network Provider pharmacy, the Participant must pay the full cost of the Drugs at the time of purchase and later submit a claim to the Administrative Office. The Plan will pay according to medical Non-Network Provider benefits summarized in the Quick Guide to Benefits. (The Prescription Drug Benefit Manager will reject any claim for a Non-Network Provider pharmacy expense; submit these only to the Administrative Office.) No home delivery option is currently available; instead, use the Mail Order Program.

8. Drug Quantity Limits. Certain Prescription Drugs have a quantity limit on the amount that you may receive at one time that may be based on the Food & Drug Administration's Drug dosing guidelines. If a Drug is covered by the quantity limit, refills are covered at the maximum quantity limit. In addition, if you choose a brand-name Drug when a generic is available, you must pay the Copayment and the difference between the cost of the generic and the brand-name Drug. For more information about these programs or for your Doctor to request an exception to the limit, please contact the Prescription Drug Benefits Manager listed in the Quick Guide to Important Contacts.

9. FDA Coverage. Drugs not yet approved by the FDA are not covered. New FDA-approved Drugs will be covered by the Plan unless an amendment states otherwise or the class of Drugs is excluded under the Plan. Drugs that do not have full approval of the FDA for the condition for which they have been prescribed, are not covered.

B. Covered Prescription Drugs.

1. What Drugs are Covered?

   a. Noninjectable federal legend Drug, except for certain over the counter drugs required to be covered when prescribed, in accordance with Health Care Reform

   b. Compounded medications

   c. Insulin

   d. Insulin needles and syringes

   e. Medi-Jector insulin injectors or other similar insulin injectors

f. Test tapes and glucose test strips

g. Retin-A for medical purposes ONLY and is subject to Prior Authorization by the Prescription Drug Benefit Manager over age 26

h. FDA-approved contraceptives for females

i. Injectable female hormones

j. Imitrex (migraine medications)

k. Diabetic supplies, including a glucose meter

l. EPI Pen

m. Injectable testosterone

n. Injectable Depo-Provera contraceptive medication limited to one (1) injection in any 90-day period

o. Erectile Dysfunction Drugs (limited to six (6) tablets per month)

p. AIDS medications, only if Prior Authorization is obtained

q. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, which are provided at no charge when obtained at a network retail pharmacy location.

2. What Drugs are Not Covered? The following are excluded from coverage unless specifically listed as Covered Drugs:

a. Allergy serum

b. Products for treatment of photoaged skin for Participants age 26 or older, unless Medically Necessary for medical condition.

c. Retin-A for nonmedical purposes

d. State Restricted Drugs

e. Non-prescription contraceptive medications or devices for males

f. Fertility Drugs

g. Smoking Deterrents

h. Amphetamines, except certain Drugs used to treat attention deficit disorder and subject to Prior Authorization

i. Anorexiants (weight loss drugs)

j. Immunizing Agents, (except immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are provided at no charge when obtained at a network retail pharmacy location), biological sera, Blood or Blood Plasma

k. Therapeutic devices or appliances

l. Drugs not listed on the Federal Legend except certain over the counter drugs required to be covered, when prescribed, in accordance with Health Care Reform

m. Cosmetic Agents such as facial wrinkle products, pigmenting products, scar treatment products, and Drugs whose primary purpose is to promote or stimulate hair growth or remove hair

n. Drugs labeled "Caution - Limited by Federal Law to Investigational Use" or similar warning, or Experimental Drugs, even though a charge is made to the individual

o. Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental compensation or occupational disease laws or any state or governmental agency, or medication furnished by any other Drug or medical service for which no charge is made to the Participant.

p. Medication that is to be taken by or administered to an individual, in whole or in part, while a patient in a licensed Hospital, rest home sanitarium, extended care facility, skilled nursing facility, convalescent Hospital, nursing home or similar institution that operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

q. Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

r. RU 486 abortion pill.

s. Dsuvia. Expenses related to the pharmaceutical drug Dsuvia.

t. Drugs that do not have full approval of the FDA for the condition for which they have been prescribed, are not covered

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 9. DENTAL BENEFITS

A. How the Dental Plan Works – Choice of Dental Plans

Employees and their Dependents covered under the Plan are eligible for dental coverage. Each Employee may elect to be covered under one of two plans. To receive dental benefits, you must submit a properly completed Dental Enrollment form to the Administrative Office.

Dental PPO Plan or **Managed Care Dental Plan.**

SCHEDULE OF DENTAL BENEFITS Plan Year: June 1 – May 31		
Benefit Description	**Dental PPO Plan**	**Managed Care Dental (MCD) Plan**
Network Used:	Nevada Dental Benefits (NDB)	Nevada Dental Benefits (NDB)
Dental Plan Year Maximum	$3,000 per person	No maximum
Dental Plan Year Deductible	$50 per person only if a non-network (non-NDB) dental provider is used This deductible does not apply to services performed by in-network (NDB) dental providers	No deductible
Preventive Dental Care Services	100% no deductible* These costs are not applied to the Dental Plan Year Maximum	Prophylaxis (cleaning) One and Two per Year: 100% no deductible Third Prophylaxis (cleaning) per Year: copayment of $65/visit for adult and $45/visit for child
Basic Dental Services	80% after deductible	Copay varies
Major Dental Services	50% after deductible	Copay varies
Orthodontic Services	$2,500 per person, with 50% coinsurance (in or out-of-network).	One-time $850 copay that includes: $200 for start-up fee. $100 paid at inception of care (banding), $50 per month to a maximum of 11 months; fee includes x-rays, tracings and study models. Adult orthodontia payable with a $3,400 copayment for a 24-month treatment period. This copayment includes necessary radiographs, tracings, study model, photographs, application of the braces (banding), 24 months of care and one set of retainers. Treatment beyond 24 months is a copayment of $125/month.

Annually, each Employee will be given the opportunity to change dental plans. This change may only be made during the "annual open enrollment period." The Administrative Office can provide information about open enrollment dates and details regarding each program not addressed in this booklet.

B. Dental PPO Plan.

The Plan utilizes an independent dental Preferred Provider Organization ("PPO" or "Network") called Nevada Dental Benefits ("NDB"). Please visit www.nevadadentalbenefits.com for a list of participating Dentists.

1. What Benefits Are Covered Under the Dental PPO Plan? Dental Benefits are payable for preventive, basic and major dental services. Basic and major dental services are subject to the benefit maximum of $3,000 per plan year per eligible person. Preventive services are not subject to the benefit maximum.

    a. *Diagnostic and Preventive Services - Paid at 100% of Allowable Expenses, no Deductible*

        (1) Oral examination (periodic); limited to two (2) each plan year.

        (2) Emergency examination and treatment to alleviate pain. (Only if no other service performed on the same day.)

        (3) Full-mouth x-rays, including bitewing, limited to once during any 24-month period.

        (4) Bitewing x-rays, limited to two (2) each plan year.

        (5) Prophylaxis (teeth cleaning), limited to three (3) each plan year .

        (6) Topical application of fluorides, limited to once each plan year and to children under the age of 18.

        (7) Biopsy and examination of oral tissue.

        (8) Bacteriologic cultures, pulp vitality tests, diagnostic models (when not required for prep) and miscellaneous tests and laboratory examinations.

        (9) Space maintainers.

        (10) Sealants – Limited to once for posterior teeth only on children under age 19.

    b. *Restorative Services - Paid at 80% of Allowable Expenses*

        (1) Amalgam, Silicate cement, acrylic or plastic, composite or porcelain restorations. Posterior composite restorations are covered.

(2) Gold foil and gold inlay restorations. (Five (5)-year replacement limitation.)

(3) Recement inlays and crowns; remove crowns and decay.

c. *Endodontic Services - Paid at 80% of Allowable Expenses*

(1) Pulp capping.*

(2) Pulpotomy.

(3) Periapical services; apicoectomy.

(4) Root canal therapy.

*Direct and indirect pulp caps are limited to teeth where decay radiographically encroaches on the pulp of the tooth.

d. *Periodontic Services - Paid at 80% of Allowable Expenses*

(1) Treatment of periodontal and other diseases of the gums and mouth tissues.

(2) Gingival curettage and gingivectomy. Periodontal scaling and root planing, except that periodontal scaling is limited to a depth of 4 mm or more and payment allowed for each quadrant is allowed once per plan year only (with one-half (1/2) benefit when four (4) or less teeth are in a quadrant).

(3) Osseous surgery.

(4) Adjunctive services - crown splinting; occlusal adjustment, Periodontal maintenance is limited to one treatment per three (3) months if the patient has a history of prior scaling and root planning.

(5) Debridement – limited to new patients only.

e. *Oral Surgery - Paid at 80% of Allowable Expenses*

(1) Simple and surgical extractions (including local anesthesia and routine postoperative care).

(2) Alveoplasty.

(3) Surgical excision of inflammatory lesions, tumors, cysts and bone tissue.

(4) Treatment of fractures and dislocations.

(5) Repair of traumatic wounds and other repair procedures.

f. *Other Services - Paid at 80% of Allowable Expenses*

(1) General anesthesia (administered by oral surgeon only).

(2) Professional consultation (diagnostic service provided by a physician or Dentist other than a practitioner providing treatment).

(3) Professional visits – house calls, Hospital calls, office visit, during regularly scheduled office hours (no operative services performed).

g. *Prosthodontics Services - Paid at 50% of Allowable Expenses*

(1) Complete and partial dentures, including adjustments and relines for a six (6)-month period. (Five (5) year replacement limitation)

(2) Temporary dentures and repairs to dentures.

(3) Fixed bridgework and crowns. (Payment is made on seating dates and not prep dates. Five (5)-year replacement limitation unless Medically Necessary.)

(4) Dental implants, subject to the plan year maximum for dental benefits.

(5) Dental relines. (Limited to no more than once at least six (6) months following an immediate denture and to no more than once every five (5) years thereafter.)

(Payment is made on delivery dates and not prep dates.)

h. *Orthodontia Services* – Paid with a $2,500 annual maximum with 50% coinsurance. Available for in-and out-of-network services.

2. <u>What Benefits Are Limited or Not Covered Under the Dental PPO Plan</u>?

a. Any procedure that is not listed as a covered benefit.

b. Any treatment or service not provided by a Dentist, except services of a licensed hygienist under the Dentist's supervision.

c. Any treatment or service not necessary or customarily provided for dental care.

d. Dental expenses incurred in connection with any dental procedure performed before coverage becomes effective. This includes any appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge, or gold restoration for which the tooth was prepared before the patient was covered.

e. Dental expenses incurred in connection with any dental procedure performed after termination of eligibility for coverage.

f. Expense for prescribed drugs, premedication or analgesia.

g. Any service performed by a Dentist who is an immediate family member of the patient, meaning a spouse, parent, sibling, child or grandparent.

h. Any dental procedure performed for cosmetic reasons.

i. Replacement of a prosthesis which, in the opinion of the dental consultant, is or can be made satisfactory.

j. Replacement of a prosthesis for which benefits were paid under the Plan, if such replacement occurs within five (5) years from the date expense was incurred for the prosthesis, unless:

(1) Replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth;

(2) The prosthesis is temporary and is being replaced by a permanent prosthesis;

(3) The prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury; or

(4) The need for a new prosthesis arises out of Medical Necessity and Prior Authorization for the prosthesis has been obtained from a Plan's dental consultant.

k. Replacement of a lost or stolen appliance.

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

m. Any treatment for a condition that arises from or is sustained in the course of any occupation or employment for compensation, profit or gain for which you or your Dependent has or had a right to compensation under any workers' compensation or occupational disease law.

n. Any supplies or services:

(1) For which no charge is made;

(2) For which you are not required to pay; or

(3) Furnished by or payable under any plan or law of any Government, Federal or State, Dominion or Provincial or any political subdivision thereof.

o. Dental supplies or services for which benefits are paid under the Medical Plan provided by the Teamsters Local 631 Security Fund for Southern Nevada.

p. Periodic oral examinations are limited to two per plan year. There is no limit on oral examinations in case of Emergency.

q. Full mouth complete series x-rays to include bitewing, and panoramic view if taken, will be limited to once during any 24 consecutive months, unless the patient is involved in an accident. Nonroutine intraoral and bitewing x-rays are limited to need in diagnosis or treatment of a disease or injury.

r. Dietary planning for the control of dental caries, oral hygiene instruction, and training in personal periodontal care (plaque control).

s. Sedative fillings.

t. Treatment of temporomandibular joint (TMJ) conditions. See Medical Benefits.

u. Services performed outside of the U.S.

v. Emergency examination and treatment to alleviate pain if other services are performed on the same day.

w. Bleaching.

x. Tissue graft surgery for periodontal disease, except that bone and tissue grafting is covered only in conjunction with placing implants.

y. Hospital expenses incurred for dental treatment unless Medically Necessary. (Note: Not covered under Dental, but if qualifies, may be medical – hospital charges).

Your Dentist must obtain prior authorization from the Benefit Trust Fund's dental administrator for all treatment plans that will cost $750 or more, or are for major restorations (crowns, bridges, implants and dentures).

The amount of any dental charges not payable under this coverage or in excess of the maximum benefits payable will not be eligible expense under the Indemnity Medical Expense Benefit and may not be used in satisfying the Indemnity Medical deductible.

C. **Managed Care Dental Plan**. The Plan offers a Managed Care Dental Plan through Nevada Dental Benefits (NDB). The Managed Care Dental Plan contracts directly with licensed dental professionals. Please visit www.nevadadentalbenefits.com for a list of participating Dentists in NDB's Exclusive Provider Network. There are no benefits unless you use an NDB Exclusive Dental Provider.

Comprehensive dental benefits are provided under the Managed Care Dental Plan as listed below for copayments that vary depending on the service. There is no plan year maximum or deductible. Many procedures have a $0 copayment, including all preventive care. Contact NDB for a list of the current copayment rates. Specialty services require a preauthorization of benefits from the Managed Care Dental Plan. The following services are available subject to the Managed Care Dental Plan's exclusions and limitations:

- Diagnostic (exams, x-rays)

- Preventive (cleanings, sealants, fluoride treatments) One and Two per Year; No charge. Third per Year: copayment of $65/visit for adult and $45/visit for child.

- Restorative (fillings)

  Posterior composite restorations are covered with the following copayments:

Code	Description	Copayment
D2391	Composite - 1 Surface Posterior	$40
D2392	Composite - 2 Surface Posterior	$50
D2393	Composite - 3 Surface Posterior	$75
D2394	Composite - 4 Surface Posterior	$15

- Endodontics (root canals)

- Periodontics (deep cleanings, scaling, root planning)

- Prosthodontics – fixed and removable (crowns, bridges, dentures)

- Oral surgery

- Orthodontics (braces for dependent children under the age of 26 are payable with a copayment of $850 for a 24-month treatment period. Adult orthodontia payable with a $3,400 copayment for a 24-month treatment period. This copayment includes necessary radiographs, tracings, study model, photographs, application of the braces (banding), 24 months of care and one set of retainers. Treatment beyond 24 months is a copayment of $125/month).

a. General anesthesia is covered for third molar partial and fully bony extractions only. (Copayment is $50 for the first 30 minutes of general anesthesia).

b. Analgesia and non-intravenous conscious sedation is covered for pedodontic office services only.

Contact NDB for all questions concerning benefits, limitations and exclusions.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 10. VISION BENEFITS

A. How the Vision Plan Works.

Vision Care Benefits are provided by Davis Vision. You simply need to contact a Davis Vision network provider selected from the list of Davis Vision network providers and schedule your appointment. At that time, you will need to inform the Doctor's office staff that your eye care provider is Davis Vision and give them your Participant ID number. The Doctor's office will then contact Davis Vision to verify your eligibility and coverage information prior to your appointment.

Shortly after attaining eligibility, Davis Vision will send you identification cards that will provide you with your Participant ID number along with additional information about your plan. Before scheduling an appointment, please confirm that the Doctor is on the current Davis Vision network provider list. Should you have any questions, please contact the Administrative Office or Davis Vision directly at 1-800-999-5431 between the hours of 6:00 a.m. - 8:00 p.m. (Pacific Standard Time), Monday through Friday, and on Saturday and Sunday 6:00 a.m. – 1:00 p.m., or access their website at www.davisvision.com. The annual period for benefits runs from June 1 to May 31. All annual limits are applied to this 12 month period.

B. What Vision Benefits Are Covered?

Davis Vision provides the following benefits to eligible Employees and their eligible Dependents, but not more often than specified, through Davis Vision network providers:

1. Vision Examination: A comprehensive eye examination, including dilation, when professionally indicated. Available every 12 months.

2. Lenses: Standard lenses are covered in full, and many extras are included at no cost to the participant. Available every 12 months. Davis Vision participants can also select many of the most popular lens options at greatly discounted fixed prices, such as a single copayment of $40 on all progressive-type lenses.

3. Frames: Davis Vision offers many choices and a wide selection of frames. Participants, Dependent spouses and children are restricted to new frames and associated services every 12 months.

   Visionworks: The frame allowance is $180 plus a 20% discount off any overage will be applied toward any frame available in Visionworks locations.

   National and Regional Retailers: All frames are covered in full up to the plan-specified allowance of $130, plus a 20% discount off any overage that may apply.

   Davis Vision Frame Collection: In lieu of the frame allowance, participants can select any frame from Davis Vision's exclusive Collection. The Collection features three levels of frames: Fashion, Designer and Premier, with retail values of $125 - $225. The Participant may choose any Fashion or Designer frame from Davis Vision's collection, covered in full. A premier level frame will require a $25 copayment. Participants can maximize their benefit by selecting a Davis Vision Collection frame.

Non-Collection Frame: A frame allowance of $130 plus 20% off any overage will be applied.

4. Contact Lenses: Participants who select contact lenses in lieu of eyeglasses are offered an Elective Contact Lens Allowance of $130, no more than once every 12 months applicable toward any non-collection contact lenses, plus a 15% discount off any overage that may apply. Davis collection contact lenses are covered in full.

5. Non-Davis Vision Providers: An Employee or Eligible Dependent may obtain services from a non-Davis Vision optometrist, ophthalmologist and dispensing optician. However, if an out-of-network provider is selected, the patient should pay the provider the full fee for services and materials and then submit a completed Out-of-Network Claim form and an itemized bill for reimbursement to Davis Vision at the following address:

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

The Participant will be reimbursed by Davis Vision in accordance with a reimbursement schedule. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE GLASSES. REIMBURSEMENT BENEFITS ARE NOT ASSIGNABLE.

Plan benefits for services obtained from non-Davis Vision network providers are subject to the same time limits as those described for Davis Vision services, and are in lieu of obtaining these services from a network provider of Davis Vision.

When you select a Doctor from the Davis Vision network provider list, this Plan covers the visual care described here (examination, professional services, lenses, frames). Any additional care, service, and/or materials not covered by this Plan may be arranged between you and your Doctor.

C. What Visions Benefits Are Limited or Not Covered?

Extra Cost. This Plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, there will be an extra charge: (a) blended lenses; (b) contact lenses (except as noted elsewhere in this Plan); (c) coated lenses; (e) laminated lenses; or (f) a frame that costs more than the plan allowance.

There are also certain limitations on low vision care.

Covered Expenses will not include charges:

1. For any covered Expense not shown in the Davis Vision schedule of Benefits.

2. For eye examinations required by an employer as a condition of employment, except as otherwise provided under the Occupational and Safety Program.

3. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment (including laser vision correction) except as provided herein.

4. For lenses which do not provide vision correction, except as provided herein.

5. For charges for the replacement of lost or stolen lenses or frames.

6. For services or supplies furnished to a Member before the effective date of his insurance under the policy or after the date a Member's Insurance ends.

7. For services rendered by practitioners who do not meet the definition of Provider.

8. For expenses covered by any other group insurance.

9. For expenses covered by a health maintenance organization (HMO) or hospital or medical services prepayment plan.

10. For any expenses covered by any union welfare plan or governmental program or a plan required by law.

11. For medically necessary contact lenses prescribed for a Member for which prior approval was not obtained from Davis Vision or their authorized representative.

12. For laser vision correction for which prior approval was not obtained from Davis Vision or their authorized representative.

Davis Vision MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF THEIR OPTOMETRIC CONSULTANTS, THIS IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

Note: In the event of a temporary layoff or termination of employment, the Employee *cannot* continue vision coverage only. Refer to the "Special Continuation of Coverage – COBRA."

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 11. DEATH BENEFITS AND ACCIDENTAL DEATH AND DISMEMBERMENT

Schedule of Death and Accident Benefits	
	BENEFITS
Death Benefit (Full-Time Employees Only)	$20,000
Death Benefit (Non-Medicare Retirees)	$10,000
Loss of Life, Certain Catastrophic Losses	$20,000
Certain Other Losses	$10,000

A. **Death Benefit**. In the case of a Participant's death from any cause, on or off the job, while the individual is insured, the applicable insurance company will pay, subject to the terms of the group policy, and as amended from time to time, an amount equal to the amount stated below.

1. Amount. The amount of the death benefit for Full-Time Employees is $20,000 and for Non-Medicare Retirees is $10,000. Benefits are reduced by 50% for Full-Time Employees when they attain the age of 65, Non-Medicare Retirees will receive no benefits after they attain the age of 65.

2. Automatic Payment. Unless you name a Beneficiary, if you die from any cause, the death benefit will be paid as follows: to your spouse, if living; if not living, equally among surviving children; if none survives, equally to your father and mother or the survivor of them; if none of the above survives, equally among your surviving brothers and sisters; if none of the above survives you, to your executors or administrators.

3. Beneficiary Designation. If you designate a Beneficiary in writing to the Administrative Office, your death benefit will be paid to that Beneficiary, provided he survives you. If no named Beneficiary survives you, the proceeds will be paid as stated. You may change the Beneficiary by making a written request.

4. Retiree Eligibility. Retirees are only eligible for this benefit if not eligible for Medicare.

5. COBRA Participants. COBRA participants are not eligible for death benefits.

B. **Accidental Death and Dismemberment Benefit**. This coverage provides benefits for your loss of life, limbs, or the entire and irrevocable loss of sight in one (1) or both eyes, including losses from occupational bodily injuries. Benefits are payable if the loss is a direct result of bodily injury caused by an Accident, and the loss is sustained within 90 days after the Accident.

1. Amount. The full amount of the Accidental Death and Dismemberment Benefit is $20,000. Benefits are reduced by 50% at age 65, and terminate upon retirement.

2. Payment. The benefit will be paid for any of the following losses effected solely through external, violent and Accidental means on or off the job while you are covered. It is payable regardless of other benefits or insurance.

a. Full payment will be made for the following losses:

(1) Life.

(2) Both hands.

(3) Both feet.

(4) Sight of both eyes.

(5) One (1) hand and one (1) foot.

(6) One (1) hand or one (1) foot, and sight of one (1) eye.

b. Payment of half the benefit amount will be made for the following losses:

(1) One (1) hand or one (1) foot.

(2) Sight of one (1) eye.

3. What Benefits are Limited or Not Covered?

a. The total payment for all losses due to any one (1) Accident will not be more than the full amount of the benefit. The loss must take place within 90 days after the Accident.

b. Loss of sight means total and irreparable loss of sight.

c. Loss of a hand or a foot means loss by severance at or above the wrist or ankle.

d. The Accidental Death and Dismemberment Benefit does not cover loss that results from or is caused, directly or indirectly, by—

(1) Suicide, whether sane or not, unless the Plan is notified of a health related or other cause that is the source of the injury and is a protected source of injury under applicable federal law (for example, the Health Insurance Portability and Accountability Act).

(2) Ailments that are not Accidents, such as bodily or mental infirmity or disease, or medical or surgical treatment thereof.

(3) Ptomaine or bacterial infection, except only septic infection of and through a visible wound Accidentally sustained.

(4) The commission of, or the attempt to commit, an assault or felony, unless the Plan is notified of a source of the injury that is a protected source of injury under applicable federal law (for example, the Health Insurance Portability and Accountability Act).

(5) A state of war, any act of war, or an insurrection or participating in a riot.

(6) Travel in or descent from any aircraft aboard which you have any duties or give or receive any instructions.

Benefits are fully insured and administered by Lincoln Financial Group.

4. COBRA Participants. COBRA Participants are not eligible for Accidental Death and Dismemberment benefits.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 12. RETIREE COVERAGE

A. General Retiree Rules.

1. Retiree Eligibility. A Retiree is eligible for Retiree coverage only if he satisfies all of the following conditions:

   a. The Retiree retires from Active Employment with a Contributing Employer. The Contributing Employer for whom the Retiree worked has contributed to the Plan (minimum 500 hours per year or equivalent) on behalf of the Retiree as an Employee for at least five (5) of the last seven (7) years immediately preceding retirement;

   b. The Retiree is receiving a pension/retirement benefit from the Western Conference of Teamsters, or other pension/retirement plan as negotiated and stated in a Teamsters 631 Collective Bargaining Agreement;

   c. The Retiree is not eligible as an employee or retiree under any other group plan providing health care benefits (excluding Medicare and/or Medicare Supplement Plans);

   d. The Retiree has timely filed a completed written application with the Plan and timely submitted any other Enrollment or eligibility documents or information required by the Plan;

   e. The Retiree timely pays the required Self-Payment before the end of the month of coverage (Participants should make payments by the 15th of the month prior to the month they are seeking coverage to prevent disruption eligibility); and,

   f. The Retiree satisfies, complies with, and continues to satisfy and comply with all other rules and policies of the Plan, including the benefit payment recovery rules.

   For disabled Retirees otherwise eligible for Retiree coverage, the effective date of coverage shall be based on the pension certificate issue date.

2. Dependent Eligibility. Coverage is available to the lawful Dependents of an eligible Retiree, so long as the Retiree is living. See Part 1.C for the definition of a Dependent.

   a. The spouse of a Retiree who retired prior to October 1, 2002 is eligible so long as the spouse was the lawful spouse of the Retiree when the Retiree first became eligible for Retiree coverage and was covered by the Plan at that time.

   b. The spouse of a Retiree who retired on or after October 1, 2002, is eligible, so long as the spouse was the lawful spouse of the Retiree throughout the entire year prior to the date the Retiree first became eligible for Retiree coverage and was covered by the Plan.

      Surviving spouses, upon attaining age 65, shall be considered for Retiree coverage, rather than Active Employee coverage.

c. If a Retiree dies while covered under this Plan, his/her covered/eligible spouse remains eligible for coverage until remarriage or other event of ineligibility stated in these Retiree rules or other Plan rules.

d. If a Retiree dies before s/he has timely applied or has been approved for Retiree Coverage, but otherwise meets all of the qualifications for Retiree Coverage in accordance with Part 12.A.1 of the Plan, then the surviving spouse will be eligible for Retiree Coverage. To be eligible in this circumstance, the surviving spouse must meet all of the other qualifications for Dependent Eligibility outlined in Part 12.A.2.

e. A surviving spouse may not add Dependent(s) after the death of the Retiree.

f. Any Dependent, including a surviving spouse, is eligible only if the Dependent was eligible and enrolled as a Dependent while the Retiree was covered as an Active Employee prior to the date the Retiree first became eligible for Retiree coverage, and the Dependent satisfies and complies with all other rules and policies of the Plan, including the Benefit Payment Recovery Rules.

3. Delayed Enrollment Eligibility. If a Retiree, otherwise eligible for Retiree coverage, becomes covered as a Dependent under his/her spouse's plan, or if the Dependent spouse of a Retiree is covered under another group plan at the time the eligible Retiree elects coverage under the Plan's Retiree coverage, then either or both may delay their Enrollment in Retiree coverage and are eligible to select Retiree coverage within 60 days of their ceasing to be covered under another group plan, so long as coverage for them has been continuous and there has been no break in coverage. Retirees or a Dependent spouse of a Retiree who delay their Enrollment in Retiree coverage and who have a Dollar Bank upon retirement may keep the Dollar Bank and use it when he or she elect coverage in the future, subject to the requirements of Part 12.A.8.b. If a Retiree elects COBRA from the Plan at the time of Retiree eligibility (or, if the Retiree has an existing Dollar Bank at the time of Retiree eligibility, then following full use of such Dollar Bank) while the Retiree awaiting approval of a pension/retirement benefit from the Western Conference of Teamsters (or other pension/retirement plan as negotiated and stated in a Teamsters 631 Collective Bargaining Agreement) for which the Retiree has timely and appropriately applied, then the Retiree is eligible to select Retiree coverage within 60 days of notice of approval of such pension benefit and may be reimbursed COBRA premiums for the period from his or her retirement date to the date of enrollment as Retiree in the Plan.

In addition to the ability to pay COBRA premiums at the time of Retiree eligibility referenced above, a Retiree may obtain interim coverage under this Plan for no more than six months while waiting for approval of pension benefits by providing a copy of his or her benefit application sent to the Western Conference of Teamsters and proof of receipt. If the Retiree is deemed ineligible for pension benefits, the Retiree must pay back any benefits received on behalf of the Retiree or his or her Dependents during the period of interim coverage.

4. Additional Eligibility Requirements for Retirees and Dependents.

a. *Current Complete and Accurate Eligibility Information*. To be and remain eligible for Retiree coverage, the Retiree and/or Dependents must agree to the

following obligations. Participating in, and accepting coverage under, Retiree coverage signifies the person's agreement to be bound to the following:

(1) The Retiree represents and warrants to the Plan that all information on the Retiree's Enrollment forms is true, complete and current as of the date the Retiree signs the Enrollment card.

(2) As a continuing condition of eligibility and coverage, the Retiree must immediately notify the Board of Trustees in writing of any changes to any information on the Enrollment card, including any change in eligibility status for any Dependent. Failure to do so will be deemed an act or omission constituting fraud or an intentional misrepresentation of material fact by both Retiree and Dependent. As a result, if the Plan has paid claims, both the Retiree and the Dependent are jointly and severally liable for those claims, and for all legal and other costs of the Plan incurred in obtaining recovery of the amounts paid by the Plan unless COBRA coverage is timely elected. **Receipt of Plan benefits is consent and agreement by the ineligible person to such liability.**

(3) The Board of Trustees has the right to require of a Retiree or Dependent, and promptly receive from the Retiree or Dependent, proof of eligibility status such as marriage licenses, birth certificates, tax returns, Medicare Enrollment forms, or any other proof of eligibility or other information as the Board of Trustees, in its sole discretion, may require. The Retiree or Dependent agrees to promptly furnish such proof and information to the Board of Trustees and agrees that furnishing such proof or information to the Trustees is a precondition to the eligibility or payment of any benefits. As a continuing condition of eligibility and as a precondition to the payment of any benefits, the Retiree or Dependent must fully cooperate with the Board of Trustees, including furnishing it with such papers, documents or other data or information that the Board of Trustees may request.

(4) If the Plan pays benefits for or on behalf of the Retiree or any person listed as a Dependent of the Retiree, when the Retiree or such Dependent is not in fact eligible or entitled to benefits or if the Plan otherwise mistakenly pays benefits, the Retiree or Dependent must reimburse the Plan in full for any benefit so paid. For instance, if a Retiree gets divorced and does not report this to the Plan, the Retiree will be liable for any benefits mistakenly paid for the Retiree's former, ineligible spouse. In addition to any other remedy it may have, the Board of Trustees, in their sole discretion, may deduct or offset any such monies from future benefits. If the Plan files any legal action against the Retiree to recover such monies, the Retiree or Dependent agrees and is obligated to pay the attorneys' fees and costs of the Plan, whether or not the suit proceeds to a final judgment, and post-judgment interest on any such judgment shall be at the Plan's delinquent Contribution interest rate, not the statutory rate. **Receipt of Plan benefits is consent and agreement by the ineligible person to such liability.**

b. *Disclosure of Eligibility for or Coverage by Other Benefit Plan or Insurance*. The Board of Trustees has a right, to require of a Retiree and/or Dependent and promptly receive from the Retiree and/or Dependent information including any documents reflecting such Retiree's or Dependent's eligibility for or coverage under other benefit plans or medical insurance. Correspondingly, a Retiree or Dependent seeking coverage or benefits under the Plan shall promptly disclose or furnish, upon request by the Board of Trustees, any information including documents regarding such person's eligibility for or coverage under any other benefit plan or medical insurance.

c. *Noncompetition*. A Retiree or Dependent is eligible so long as the Retiree or Dependent is not performing work of the type covered by any Teamsters Local 631 Collective Bargaining Agreement for an employer who is not signatory to a Teamsters Local 631 Collective Bargaining Agreement and thus not supporting the Plan with Contributions. On a form satisfactory to the Trustees and at intervals or times determined solely by the Trustees, Retirees and/or Dependents must certify under oath the nature or type of any work or employment and furnish documentation, including tax returns, as a condition of eligibility and coverage.

d. *Periodic Verification*. As determined by the Board of Trustees, the Retiree must certify under oath his eligibility and that of all covered Dependents as a condition of continued coverage. The form of eligibility certification will be determined by the Board of Trustees. The Board of Trustees may require from a Retiree or Dependent such documents and papers, including tax returns, as the Board may request to determine and verify eligibility. If a Retiree or Dependent refuses to provide any such documents or papers, he and any Dependents shall not be eligible for coverage or benefits.

5. Termination of Coverage for Retirees. Coverage for a Retiree will terminate upon any of the following events:

a. The Retiree's death.

b. Termination of Retiree coverage or the Retiree program.

c. Untimely/late payment or nonpayment of any required Self-Payment.

d. Employment covered by the provisions dealing with noncompetition.

e. Coverage as an active employee (but not as a dependent) or retiree under any other group health plan (excluding Medicare and/or Medicare Supplement Plans).

f. Failure to satisfy or comply with any rule of eligibility, policy or other rule of the Plan, including these Retiree rules or other Plan rules.

6. Reinstatement of Lapsed Retiree Coverage. In the case of a lapse of a Retiree's coverage, after electing and establishing Retiree coverage, where such lapse lasts 12 months or less, the Retiree may reinstate coverage.

7. Termination of Dependent Coverage. Coverage for a Dependent will terminate upon any of the following events:

   a. Except as otherwise provided in these Retiree rules, upon the Retiree's loss of eligibility for Retiree coverage.

   b. The Dependent's death.

   c. Termination of Retiree coverage or the Retiree program.

   d. Untimely/late payment or nonpayment of a required Self-Payment.

   e. Dependent's employment covered by the provisions dealing with noncompetition.

   f. Coverage as an employee (but not as a dependent) or retiree under any other group health plan (excluding Medicare and/or Medicare Supplement Plans).

   g. For a surviving spouse, remarriage.

   h. Failure to satisfy or comply with any rule of Dependent eligibility, policy or other Plan rule.

8. Miscellaneous Retiree Rules.

   EPO Limitation. A Retiree, including Medicare-Eligible Retirees, may select only the EPO coverage. Contact the Administrative Office for information.

   a. *Dental Coverage Limitations*. Subject to the provisions concerning delayed Enrollment, dental coverage can only be selected at the time of retirement and not later. Dental coverage is not available to Retirees who do not enroll for it at the time they retire.

   b. *Use of Dollar Bank Upon Retirement*. If a Retiree has a Dollar Bank upon retirement, the Retiree may use the Dollar Bank to pay his Contribution or Self-Payments, up to the maximum permitted for Active Employees at the Retiree Contribution rate set by the Trustees until that Dollar Bank is exhausted. However, the Dollar Bank may not be used to pay for dental coverage only (medical coverage must be included).

   c. *Contributions for Work by Retirees to be Paid/Credited to Retiree Plan*. Part-time or limited time work in Covered Employment by a Retiree enrolled in Retiree coverage may require Contributions to the Plan for such part-time or limited work. The Contributions, or credits to Dollar Banks for such work, shall be paid/credited in the same manner as for Active Employees and subject to the requirements of Part 12.A.8.b.

   d. *Combining Contribution for Retirees Who are Married*. In a case where both husband and wife work part-time and are both covered by the Plan, Contributions may be combined to offset Self-Payment obligations.

e. *Reemployment*. If a Retiree returns to work after enrolling in this Plan's Retiree coverage, and thereafter again retires, he must again satisfy all eligibility rules for coverage as a new Retiree. In such a case, the coverage for the Retiree will again become effective on the first day of the month coinciding with or next following the date the Retiree again retired. In no case shall Retiree coverage commence until the expiration of active employment coverage. The Retiree will not be eligible for reentry if, because of reemployment, the Retiree has qualified for Retiree coverage under another group health care or service plan of benefits (excluding Medicare or Medicare Supplement Plan(s)).

f. *Continued Employment*.

(1) A Retiree who has not yet enrolled in this Plan's Retiree coverage and who is drawing a Teamsters' pension while eligible for active Plan coverage may continue such coverage only so long as he continues to work sufficient hours each month, without interruption (or to have sufficient dollars in his Dollar Bank) to qualify for Active Employee Plan coverage under the rules of the Plan. Such a Retiree loses eligibility for Active Employee coverage if he does not work sufficient hours each month, without interruption (or does not have sufficient dollars in a Dollar Bank) to qualify for Active Employee coverage. In such a case, the Retiree coverage available to the Retiree is EPO coverage only. Self Payments may not be used as a substitute for the Dollar Bank hereunder.

(2) Where a Retiree drawing a Teamsters' pension moves from Active Employee coverage to Retiree coverage, due to insufficient work hours per month (or insufficient Dollar Bank) to continue to qualify for Active Employee coverage or for any other reason, he is not eligible thereafter for Active Employee coverage, even if he returns to work and works sufficient hours to otherwise qualify for Active Employee coverage. He remains eligible only for Retiree EPO coverage.

g. *No Vested Right or Guarantee of Retiree Coverage*. Neither Retiree coverages nor particular types or levels of benefits are vested rights or guaranteed but may be changed, modified, reduced or eliminated at any time at the sole discretion of the Board of Trustees. Contribution rates, Prefunding Credit Values, Self-Payment rates charged to Retirees, or contribution or benefit subsidies, if any, are not vested rights or guaranteed, but may be changed, modified, increased, decreased or eliminated at any time at the sole discretion of the Board of Trustees.

h. *Annual Automatic Termination of Coverage; Annual Renewal at the Discretion of Trustees*. Health and welfare coverage for Retirees and the Retiree program automatically terminate at the end of each Plan Year. They may be renewed, continued, modified or changed, in whole or in part, at the sole discretion of the Board of Trustees by an affirmative vote of the Board of Trustees. The Board of Trustees reviews coverage for Retirees on an annual basis and determines whether to continue any Retiree benefits. If Retiree benefits and coverage are to be continued, the Board of Trustees determines the level and type of benefits and funding, including any required Contributions or Self Payments by the Retiree.

i. *Trustee Authority*. The Board of Trustees has the full and complete authority and sole discretion to create, structure, alter or modify the Retiree program, including, without limitation, particular types and levels of benefits for Retirees and Retiree Contribution or Self-Payment rates. The Board of Trustees has full and complete authority and discretion to interpret and apply the Plan rules governing Retirees' benefits, and to change or modify the Retiree eligibility rules or the benefits for Retirees, including reducing or changing benefits or providers, requiring increased or additional Copayments or Self-Payments by Retirees, or eliminating Retiree coverage altogether. The Board of Trustees has the full authority to structure, organize and implement any Retiree plan in such a manner and upon such terms and conditions as the Board in its sole discretion deems appropriate including, without limitation, creating, maintaining, raising or investing reserves.

B. **Retiree Prefunding Program**. To be eligible for the Retiree Prefunding Program, the person must satisfy the general eligibility requirements set forth in Part 12.A.

1. Description of the Program. The Retiree Prefunding Program ("Program") applies to Retirees of Contributing Employers who have made Prefunding Contributions to the Plan for a certain number of years to subsidize health and welfare benefits for Retirees of such Contributing Employers.

This Program is designed to partially offset the required Self-Payments for Retiree coverage. The amount of Self-Payments that is not offset by the prefunding must be self-paid by the Retiree. The Trustees will establish and notify eligible Retirees of the portions of the Contributions required to be self-paid. In setting this Self-Payment portion, the Trustees may consider the number of covered individuals (single, husband and wife, or family), or other factors the Trustees deem relevant and appropriate.

This Program will continue only so long as there are sufficient prefunding Contributions to adequately fund the Program, in the sole discretion of the Trustees. Rising costs of health care and other factors can diminish this prefunded offset to Self-Payments or cause it to be eliminated. There is no guarantee that money contributed under this Program will be available or sufficient to subsidize or offset Self-Payments for those on whose behalf the Prefunding Contribution were made.

2. Self-Sufficient Funding and Finances Separate from General Health and Welfare Plan. The Program is and must remain financially self-sufficient. In other words, the funding of the Program must come from and be financed by Prefunding Contributions. It is the intention of the Board of Trustees that the Program be financially free standing and independent from the general health and welfare Plan for working Teamsters and that the Program not be subsidized or financed by the general health and welfare plan for working Teamsters. If the Trustees determine that the Retiree plan is not self-sufficient from a funding/financial standpoint, the Trustees, at any time, may take such action as they in their sole discretion deem necessary, including increasing the Retiree Self-Payments to cover all costs, reducing benefits, or discontinuing this Program. If the Program is eliminated, the remaining Prefunding Contributions, if any, will continue to be used as a subsidy or offset until they are exhausted.

Neither the Program, the particular type nor level of prefunding offset to Self-Payments or the Self-Payment rates are vested or guaranteed rights, but may be changed, reduced, modified or eliminated at any time, at the sole discretion of the Board of Trustees.

3. Retiree Prefunding Credits (for covered work on or after January 1, 2007).

a. The Retiree Prefunding Credit each eligible Retiree receives from the Program depends on the dollar amount of prefunding Retiree Contributions contributed to the Plan on the eligible Retiree's behalf during each Calendar Year. For every $300 of prefunding Retiree Contributions received each Calendar Year, the eligible Retiree earns one (1) Retiree Prefunding Credit with which to offset the cost of Retiree coverage in the Plan. Prefunding dollars per Calendar Year less than $300 that are insufficient to earn a full credit do not carry over from year to year but are forfeited. There is no limit to the total amount that may be contributed or the total Retiree Prefunding Credits that may be earned.

For example, if an eligible Retiree's prefunding Contributions total $900 in a Calendar Year, the Retiree earns three (3) Retiree Prefunding Credits. If an eligible Retiree's prefunding Contributions total $1,300 in a Calendar Year, the eligible Retiree earns four (4) Retiree Prefunding Credits (no partial credits are earned for the additional $100).

b. Retiree Prefunding Credits will have a percentage subsidy value of the Self Payment Cost of the EPO Plan in which the Retiree enrolls as follows:

Number of Credits	Subsidy as a % of the EPO Plan where Retiree Enrolls
0	0%
1-9	10%
10-19	25%
20-29	50%
30-39	75%
40-49	90%
50 or More	100%

Retirees who are otherwise eligible for a subsidy but do not live in the service area for the Retiree EPO plan offered by the Plan may purchase an individual retiree health plan, and upon proof of payment in a method specified by the Plan, receive a subsidy equal to the lesser of the actual cost of the individual plan or the subsidy the Retiree would have received for the Retiree EPO plan offered by the Plan.

The Trustees may adjust the percentage subsidy values above from time-to-time in their sole and complete discretion. To find out the current Retiree Prefunding Credit value for you, please contact the Administrative Office

c. Any Retiree who performs covered work will have any additional Retiree Prefunding Credits earned calculated on an annual basis, between January 1 and April 1, and may receive additional Retiree Prefunding Credits retroactive to January 1, subject to all other rules and limitations applicable to credits.

4. Prior Service Credits.

a. Eligible Retirees whose Contributing Employers contributed on their behalf to the Supplemental Retiree Funding Program (which existed prior to January 1, 2007 and was the predecessor to this new Retiree Prefunding Program), will receive Prior Service Credits calculated in the same manner as the new Retiree Prefunding Credits arc calculated: For each $300 annually contributed during each of the five (5) years immediately preceding January 1, 2007, the person will receive one (1) Prior Service Credit. However, there is a maximum of 15 Prior Service Credits that can be earned and credited.

b. Like the Retiree Prefunding Credits, amounts less than $300 per year to earn one (1) full credit are not carried over to another year, do not earn partial or fractional credit, and are forfeited. For example, a Retiree whose employer contributed $400 in 2006 under the Supplemental Program would receive 1 Prior Service Credit. The remaining $100 is forfeited. A Retiree whose employer contributed $600 would receive two (2) full Prior Service Credits. For another example, if in each of the last five (5) years, the employer contributed $1,800, the total Prior Service Credits earned would be 15, the maximum for Prior Service Credits.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 13. OTHER IMPORTANT PLAN RULES

A. **Dividing Payment of Benefits Between Multiple Plans: Coordination of Benefits**. This Plan coordinates this Plan's benefits with other similar plans under which an individual is covered so that the total benefits available will not exceed 100% of the allowable charges. The Plan provides for coordination of Prescription Drug benefits under the Indemnity Medical Plan by reimbursing Copayments that are equal to or less than the average wholesale price. All benefits provided under the Plan are subject to the following additional provisions and limitations.

1. General Rule. When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable charges. No plan pays more than it would without the coordination provision.

   The plan covering a patient as a Dependent is secondary to any plan covering the patient in the patient's own name (not as the Dependent of someone else), whether coverage in the patient's own name is as an employee, retiree, COBRA participant or any other form of coverage that is not the result of the patient's status as someone else's Dependent. The form of coverage on which the patient is a Dependent makes no difference.

2. Definitions for Determining COB.

   a. "*Allowable Charge*". An "allowable charge" is any necessary, reasonable and customary expense covered, at least in part, by one of the plans of the same type (medical or dental care).

      When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Charge and a benefit paid.

   b. "*Plan*". For purposes of Coordination of Benefits only, the term "Plan" means (1) group, blanket or franchise insurance; (2) service plan contracts, group practice, individual practice and other prepayment coverage; (3) labor-management trustees plans, union welfare plans or employee benefit organization plans; and (4) any coverage under governmental programs, and any coverage required or provided by any statute, that provides benefits or services for medical, Hospital, dental care or inpatient Prescription Drug benefits or treatment.

      When a person is covered under this Plan in more than one capacity either (1) as an Employee and as a Dependent of another Employee or (2) as a Dependent child of more than one (1) Employee, coverage of the person in each capacity will be considered as a separate Plan for the purposes of this provision, and this provision will apply separately to the coverage of the person in each capacity as though such coverage were the primary Plan and coverage of the person in the other capacity were the secondary Plan.

      This Plan shall not be required to determine the existence of any other plan, or the amount of benefits payable under any plan other than This Plan. The payments of benefits under This Plan shall be affected by the benefits payable

under other plans only if the Plan is furnished with information concerning the existence of such other plans by the Eligible Individual or insurance company, organization, agency of government or person.

c. "*Plans*". "Plans" means these types of medical and dental care benefits: (a) coverage under a governmental program (except Medicaid but including Medicare*) other than for a motor vehicle insurance contract, or (b) group insurance or other coverage for a group of individuals, but not including (1) franchise insurance or (2) student coverage obtained through an educational institution. (*See "Modified Health Care Coverage for Persons Eligible for Medicare" below.)

3. Determination of Primary and Secondary Plans. A Plan without a coordinating provision similar to this provision is always the primary Plan. If all Plans have such a provision, the first of these rules to apply determines the order of payment and later rules have no impact:

a. The Plan covering the patient as a Dependent is secondary to any Plan covering the patient in the patient's own name (not as the Dependent of someone else), regardless of whether the coverage in the patient's own name is as an employee, retiree, COBRA participant or any other form of coverage that is not the result of the patient's status as someone else's Dependent. The form of coverage (active, retiree, COBRA, etc.) on which the patient is a Dependent makes no difference.

b. If a child is covered under both parents' Plans, and the parents are not divorced, the Plan of the parent whose birthday falls earlier in the year is primary; but if both parents have the same birthday, the Plan that covered the parent longer is primary.

c. If a child is covered under both parents' Plans and the parents are divorced, their Plans pay in the following order:

(1) if a court decree has established financial responsibility for the child's health care expenses, even if the decree is not a QMCSO, the Plan of the parent with this responsibility;

(2) the Plan of the parent with custody of the child;

(3) the Plan of the stepparent married to the parent with custody of the child;

(4) the Plan of the parent not having custody of the child (assuming such parent is not already responsible for health care expenses under item (a) above).

d. The benefits of a Plan that covers an active employee and the active employee's covered dependents are determined before those of a plan that covers the individual as a laid-off employee or retiree and the laid-off employee's covered dependents.

e. The benefits of a Plan that covers an active employee or an active employee's Dependents will be determined before those of a plan that covers the person as a COBRA Beneficiary or Dependent of a COBRA Beneficiary, as a retiree or a retiree's Dependent, or through other forms of 100% Self-Payment.

f. If your spouse is eligible as an Employee, he will be eligible both as an Employee and as a Dependent with coordinated benefits. When both husband and wife are covered as Employees, their children are Eligible Dependents of both with coordinated benefits.

g. If none of the above applies or each Plan points to the other as primary, the Plan covering the patient longest is primary.

Where this Plan is coordinating benefits with another plan which has entered into a preferred provider arrangement with a medical or Hospital provider, in no event will Allowable Expenses exceed the least of (a) the normal charges billed for the expense by the provider; or (b) the contractual rate for such expense under a preferred provider contract between the provider and this Plan or between the provider and the other Plan.

Where this Plan is coordinating benefits with a Health Maintenance Organization, this Plan will coordinate only on Copayments, surcharges or other charges that the patient is legally obligated to pay out of pocket to the provider for services given to the patient.

h. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the longer or shorter coverage rule in paragraph (g) above applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph (b) to the Dependent child's parent(s) and the Dependent child's spouse.

4. Modified Health Care Coverage for Persons Eligible for Medicare. If (a) the Employee is an Active Employee age 65 or over and has elected to retain this Plan as his or her primary coverage, or (b) the Dependent spouse age 65 or over of an Active Employee and has elected to retain the Plan as his or her primary coverage, then the COB provision above will not apply to that person's Medicare coverage. Instead, Medicare will adjust its benefits, as required by law, to take into account benefits payable under this Plan. In the case of end-stage renal disease (ESRD), this Plan will be the primary payer only for the first 30 months of treatment. After 30 months, Medicare becomes the primary payor, and this Plan will be secondary (and pay as secondary without regard to whether the Employee has, in fact, enrolled in Medicare).

5. Dual Coverage Penalties Inapplicable. In any case where this Plan is determined to be Secondary according to the rules above, or otherwise, and if the other Plan contains any provision reducing its benefits when the patient is covered by more than one (1) Plan ("Dual Coverage Penalty"), this Plan shall pay as Secondary, and determine secondary benefits, without regard to the other Plan's Dual Coverage Penalty and as if the other Plan did not contain such a provision.

For purposes of this rule, it makes no difference how the Dual Coverage Penalty is denominated by the other Plan, whether as a subplan, wrap-around plan, an eligibility rule, a Coordination of Benefits rule, or in some other manner. Whether the Other Plan contains a Dual Coverage Penalty with respect to this Plan's liability as Secondary Coverage shall be determined in the sole, absolute and complete discretion of the Trustees of this Plan, which determination shall be binding and final upon all interested parties, subject only to this Plan's Claims and Appeals Procedures in Part 13.D.1.

B. Third Party Recovery Rules.

Important Note: This Plan does not provide benefits for work-related injuries or illnesses, or injuries or illnesses when there is another source for payment of the related claims, including but not limited to workers' compensation coverage or a third party who has caused the injury or illness (collectively and interchangeably referred to as "Third Party"). The rules below provide very limited exceptions to this general Plan exclusion so that you and your eligible Dependents may receive Plan benefits on a conditional, interim basis while you take steps to recover from workers' compensation or another Third Party responsible for the injury or illness and/or related medical care expenses.

The following provisions set forth the Plan's rights and ***your obligations*** in any case where you seek conditional, interim Plan benefits while you pursue a recovery from workers' compensation or a Third Party who has caused your injury or illness. The Plan is not an insurance company, nor is it a for-profit entity. The contributions that fund Plan benefits do not come from insurance premiums, but instead from limited employer contributions negotiated by the Union, and employee contributions, which must be protected and preserved for the benefit of all Plan beneficiaries as a whole. Accordingly, the Trustees shall, in their sole and complete discretion, interpret and apply these rules broadly to ensure the maximum Plan recovery in any case, and their interpretation shall be binding on all parties and any reviewing court or other tribunal.

Failure to comply with any provision of these rules may result in immediate ineligibility for any Plan benefits.

1. "Third Party" means the person or organization (including workers' compensation) that is or may be liable or financially responsible for the injuries or illness and/or related medical care expenses, even if that person is a relative and/or another Participant in this Plan. *The Plan's Third Party Recovery Rules do not extend to first-party insurance, which is an insurance policy (other than workers' compensation) under which the injured person is a named insured.*

2. "Third Party Recovery" means any money sought or received by an injured or ill Participant or Dependent (or by anyone on their behalf), as payment to themselves or any other party (including but not limited to a special needs trust, charity, fund, or any other entity), from workers' compensation or other Third Party, where the money is sought or received in relation to the illness or injury (not necessarily for the payment of medical claims). The term Third Party Recovery is not limited to money recovered specifically for medical expenses or to satisfy the Plan's repayment rights under these rules. The Plan's rights under these rules apply *no matter how the recovery is labeled or denominated, which label or denomination shall be disregarded when applying these rules.* Any issue regarding whether a particular expense is related to a particular illness or injury shall be resolved by the Trustees, in their sole and complete discretion. Where the Third Party Recovery is not from workers' compensation, the Plan's Third Party Recovery rights

herein are limited to 100% of the Third Party Recovery obtained by the Participant or Dependent. Where the injury or illness is work-related, amounts not recovered out of a workers' compensation recovery may be recovered by the Plan directly from the Participant and injured/ill Dependent.

3. Duty to Cooperate; Liability to Plan for Attorneys' Fees.

   a. As a condition precedent and to receive ongoing Plan benefits generally and for the conditional, interim Plan benefits described under these rules, the Participant and any injured or ill Dependent, their attorney or anyone acting on their behalf, must not take any action that would prejudice the Plan's rights hereunder, and must fully cooperate in doing what the Plan deems necessary to assist the Plan in obtaining the Third Party Recovery described in these rules. Such cooperation includes but is not limited to immediately and fully disclosing the amount and circumstances of any Third Party Recovery, and it shall be a violation of these rules to enter into any confidentiality agreement purporting to prevent such disclosure to the Plan.

   b. If the Participant, Dependent, their attorney or anyone acting on their behalf fails to fully cooperate with the Plan under these Third Party Recovery Rules, including but not limited to the failure to promptly respond to information requests and updates, and to promptly turn over any Third Party Recovery identified by the Trustees, the Participant and Dependent shall be liable for the Plan's attorneys' fees and costs incurred pursuing such cooperation or recovery, prior to, during and after any necessary legal action, whether or not formal legal action is filed or proceeds to judgment, and any judgment in favor of the Plan in such a case shall bear interest at 18%, not the applicable statutory rate.

   c. Any dispute or controversy regarding application of these rules that arises before the Participant or Dependent has obtained a Third Party Recovery may be resolved by a declaratory judgment action in the appropriate state or federal court. Any right of the Participant or Beneficiary to challenge the ripeness of such a case is waived and attempting to do so shall be a failure to cooperate under these Third Party Recovery Rules.

   d. In any action to resolve any dispute regarding the application of these rules the Plan shall not be required to join any other party (including but not limited to the third party or third-party insurance provider), and shall be entitled to, and the Participant and/or Dependent shall stipulate to, a preliminary injunction preventing the distribution, transfer or dissipation of any Third Party Recovery money identified by the Plan.

4. Precondition to Eligibility for Benefits and Plan Payment of Benefits.

   a. The right of any person to receive Plan benefits is subject to and conditioned on that person's, and his or her attorney's or other representative's, full agreement and acquiescence to every term of the Plan, including these Third Party Recovery Rules.

   b. If the Participant or Dependent hires an attorney in relation to the illness or

injury, he or she agrees to obtain the full cooperation and agreement of the attorney to fully comply with these rules and the Repayment Agreement.

c. Before the Plan pays any benefits, and in order for any person to be eligible for benefits under these Third Party Recovery Rules, the Participant and any injured or ill Dependent seeking Plan benefits must sign a separate agreement with the Plan, in form and substance acceptable to the Plan, to (jointly and severally) repay the Plan and otherwise fully comply with these Third Party Recovery Rules (the "Repayment Agreement"). The Repayment Agreement is a contract enforceable as a matter of state law, independently from, and in addition to, enforcement of it as a Plan document, enforcement of the terms of this Plan under any applicable state or federal law, or enforcement of the Plan's rights in equity.

d. In any case where a Participant or Dependent, or an attorney or other representative, fails to fully acknowledge, comply and cooperate with these Third Party Recovery Rules, including prompt, full and accurate communication and responses to the Plan and its representatives, such Participant and each and every Dependent of such Participant shall have all Plan benefits suspended pending full recovery by the Plan, subject to the Trustees' discretion to waive benefit suspension for good cause shown as determined in the sole discretion of the Trustees. The Board of Trustees, in its sole discretion, may, in addition to any other rights the Plan may have, deduct or offset the money it is due (including attorneys' fees and costs and interest described in subsection 3(b) above) from future benefits to the Participant and/or any of his Dependents.

e. If the injured or ill person is a minor, the minor's parent/legal guardian must sign the required Repayment Agreement. By doing so, the parent/legal guardian certifies that he or she is the parent and/or legal guardian of the minor, has fully explained the Repayment Agreement to the minor, will take whatever legal action is required on behalf of the minor to make the Repayment Agreement and these rules legal and binding on the minor, and personally guarantee the Plan's Third Party Recovery rights.

f. A Participant and injured or ill Dependent seeking benefits in circumstances described in these Third Party Recovery Rules shall be required to execute a Stipulation and Order for Entry of Preliminary Injunction, on a form prescribed by the Plan, which the Plan may file in court at any time the Plan determines that there has been a failure to fully cooperate and comply with the these rules.

5. Plan Rights. The Plan's Third Party Recovery Rights are cumulative and may be asserted by the Plan singly, together, or in any combination as the Board of Trustees, in its sole discretion, determines. The Plan's Third Party Recovery Rights include but are not limited to:

a. *Lien and Express Trust Rights*. To the extent the Participant or Dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, recovers money from a Third Party, or as a result of workers' compensation, in relation to an injury or illness for which the Plan has paid or later pays benefits, the Plan shall have a first priority lien on the amounts

so recovered. The Participant or Dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, holds all such money in trust, as expressly provided hereby, for the Plan and must pay such amount, up to the amount of claims the Plan has paid to date (or as of such later date on which the Plan demands reimbursement for additional or other claims paid) to the Plan within ten (10) days of receipt by such entity or person (or demand by the Plan). Prior to payment, any person holding or controlling such funds is a fiduciary as to the Plan's assets thus held.

b. *Repayment Rights*. The Participant or Dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, is obligated to fully reimburse the Plan to the extent of any recovery from a Third Party, or workers' compensation, or other similar sources, in relation to an injury or illness for which the Plan has paid or later pays benefits. Before the Plan pays any benefits and in order for the Participant or Dependent to be eligible for benefits, the Participant and injured or ill Dependent, and their attorney, must sign a separate agreement with the Plan, in form and substance acceptable to the Plan, to repay the Plan under these Rules and fully abide by them.

c. *Assignment of Funds*. Any funds due as the result of a Third Party's conduct or financial responsibility hereunder shall be deemed assigned to the Plan prior to receipt by the Participant or Dependent, or their agent or attorney, or payment to any person, provider or entity on behalf of the injured person. Such funds, thus assigned, are the sole property of the Plan and any party taking any action contrary to the Plan's rights to such funds does so in violation of such rights. Any party or entity in possession of such funds following such assignment to the Plan holds such funds in trust, and as a fiduciary, for the exclusive benefit of the Plan and upon demand of the Plan must immediately transfer all such amounts to the Plan.

d. *Subrogation*. The Plan has a right of subrogation to the extent of all benefits paid under the Plan as a result of a Third Party's wrongful act or negligence that causes an injury to the Participant or Dependent. The Plan has the right but not the obligation to assert any and all rights the Participant or Dependent might have against the Third Party in order to recover an amount equal to the amount of benefits paid under the Plan. The Plan's subrogation rights also apply to workers' compensation injuries or illnesses for which the Plan paid benefits. The Plan is subrogated and succeeds to the Participant's or Dependent's rights, which rights are assigned to the Plan.

6. Rejection of Make Whole, Common Fund, and other doctrines. The Plan's Third Party Recovery Rights, as described herein, apply without regard to whether the amount recovered is sufficient to make the injured party whole, and without reduction for costs or fees incurred by the injured party in obtaining such recovery. The "Make Whole," "Common Fund," and any other doctrine having the effect of reducing the Plan's recoveries under these rules, are hereby specifically rejected by the Plan and any Participant or Dependent seeking Plan benefits. Should any court or other competent tribunal rule that, despite this provision, any such doctrine applies at common law, causing any reduction in the Plan's recovery under these rules, the Participant and Dependent's contractual obligations to the Plan under the Repayment Agreement shall be

increased in an equal amount.

7. Future Claims. The Plan's Third Party Recovery rights extend to additional benefits paid after receiving initial (or multiple) reimbursements under these Rules to the extent of any claims incurred after the date of such reimbursement; future claims by the Plan under these rules are not extinguished by resolution of past claims. Insistence by any party that the Plan waive future claims to receive reimbursement under these rules shall be deemed a failure to cooperate.

8. Workers' Compensation Claims. Regarding workers' compensation claims, the Participant or Dependent must timely and diligently make and keep appointments, file papers, including claim forms, attend hearings and pursue all appeals available, including to the extent provided by any separate Plan policies that apply, and otherwise fully cooperate and act in good faith with others in connection with such workers' compensation claims. If workers' compensation benefits are not available for a work-related injury due to any failure of the Participant or Dependent to comply with this provision, or misconduct of the injured person at the time of injury or during the course of subsequent proceedings, the Plan's Third Party Recovery Rights in such cases shall be preserved and enforceable for the recovery of ineligible benefit payments against the Participant and an injured or ill Dependent.

C. How to File a Claim.

1. For Death Benefit. Whenever there is a claim, a certified copy of the death certificate showing the deceased's Social Security Number should be sent to the Administrative Office immediately. Payment of the claim will be promptly made upon the receipt of all necessary proof by the Administrative Office and the Insurance Carrier for the insured benefit.

2. For Accidental Death and Dismemberment Benefit. The Administrative Office should be notified immediately. Payment of the claim will be promptly made upon the receipt of all necessary proof by the Administrative Office and the Insurance Carrier for the insured benefit.

3. For Prescription Drug Benefits from a Network Pharmacy. It is not necessary to file a claim if you obtain your Drugs at a Network Provider pharmacy or from the mail order service. For Non-Network Provider Drug claims, send the claim to the Administrative Office.

4. For Medical, Dental and Behavioral Health Claims.

   a. Write or call the Administrative Office.

   b. Benefits from the Plan cannot be assigned to providers or anyone else. As an accommodation to Eligible Individuals, the Plan will make a direct payment to providers. Payment will be made upon receipt of itemized bills and properly completed claim forms.

5. **Claim Filing Time Limits**: The time limit for the initial filing of claims for Indemnity Medical Plan benefits including outpatient prescription drug claims and behavioral health

claims, Dental Plan claims and Vision Plan claims is **12 months from the date of service**. No Plan benefits will be paid for any claim submitted after this period.

D. **Denial of Claims and Appeals Procedures**. These Claims and Appeals Procedures supersede and replace all previous claims and appeals procedures adopted by the Trustees.

These procedures are intended to comply with the timing, content and administrative requirements of, and shall be made effective on or before the dates required by, ERISA and the Internal Revenue Code, and all applicable regulations, including, without limitation, ERISA Sections 503 and 715, Department of Labor Regulations 29 CFR Part 2560.503-1 and 29 CFR Part 2590.715-2719, as amended, and other interpretive guidance promulgated thereunder, including any regulations or other guidance issued after July 1, 2011. Any provision of these procedures that is determined to conflict with such laws and regulations shall be deemed to be displaced by such laws and regulations, which shall govern the Claims and Appeal Procedures.

All claims and appeals for benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Any Beneficiary may request a copy of these procedures from the Administrator for no charge, except that a reasonable copy charge may apply.

1. Claims and Appeals Procedures. These are the procedures for when a medical, Prescription Drug, behavioral health or dental Claim is denied and you want to appeal the denial to the Board of Trustees.

Important note regarding unofficial claims: Claims, inquiries, questions and requests regarding eligibility, Enrollment or available benefits made before the expense is incurred are not "Claims" for purposes of this section, and are not subject to the Plan's claims and appeals procedures, unless Preauthorization is required by the Plan. This is true even if these types of unofficial claims are referred to as "claims" by the Administrator, Trustees or anyone acting on their behalf. Such unofficial claims and questions will be responded to in a prompt manner, but carry no obligation to apply these procedures and no right to appeal under these procedures.

a. *Making a Claim*. There are no fees or charges to file a Claim or to appeal a benefit decision. These procedures apply whenever a Claim for services that have already been received by you is not granted in your favor. A "Claim" is a written request by you, your authorized representative, or a health care provider, that the Plan pay benefits. You may authorize another person to make a claim for you only in writing, signed by you. However, in an emergency, your Doctor may make a claim on your behalf. An oral request is not a claim, but a facsimile ("fax") is acceptable. Once a Claim is made by you or your authorized representative, the rights of any other person or entity to make a claim for the same benefits are terminated.

b. *Prior Approval for Treatment*. These procedures also apply whenever you are required to obtain Prior Approval before a course of treatment, which is also considered a "Claim." You should review the Plan sections that discuss your treatment carefully to determine whether Prior Approval (or "Preauthorization") is required and who to ask for approval.

c. *Deciding a Claim*. Whether a claim is granted in your favor will be determined based on the Plan Documents. The Trustees have full discretion to interpret and apply the Plan's provisions. However, the provisions of the Plan will be interpreted consistently in similar circumstances and similar past appeals, if any, will be reviewed when your appeal is decided.

d. *When Will Your Claim be Decided*? The time periods in subsections (1) through (5) below apply to health care Claims. The time periods set forth in subsection (6) below applies to all disability claims. For all other types of Claims, the time periods set forth in subsection (7) below apply.

(1) *Urgent Care*. If you have a claim for Urgent Care and you provide sufficient information to determine whether benefits are covered, your Claim will be decided as soon as possible and not later than 72 hours after the Plan receives your Claim. If you have a Claim for Urgent Care and you do not provide sufficient information to determine whether benefits are covered, you will be told within 24 hours what additional information is needed to decide your Claim. You will then have 48 hours to provide the additional information.

The Plan will notify you of its decision as soon as possible and within 48 hours after (a) all necessary information is provided, or (b) the 48 hours you have in which to provide the necessary information ends, whichever is sooner.

(2) *Ongoing Treatment*. If you are receiving ongoing treatment over a period of time, and the Plan determines to reduce or discontinue that treatment, you will receive notice early enough for you to appeal that decision and receive a decision on your appeal before the ongoing treatment is reduced or discontinued. If you are receiving ongoing Urgent Care treatment and make a Claim to continue such treatment, a decision will be made within 24 hours after receipt of the claim.

(3) *Claims Made Before Treatment*. If you make a Claim for benefits before you receive the benefits, and neither subsections (1) nor (2) above apply, your Claim will be decided within a reasonable time no longer than 15 days after receipt of your claim. However, an additional 15 days may be needed if there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 15 days and told whether additional information is needed to decide your claim. You will have at least 45 days to provide the additional information. Keep in mind that only where Preauthorization is required will such a request prior to receiving benefits be an official Claim.

(4) *When Preauthorization is Required*. The Plan will notify you if your request for Prior Approval is not sufficient to be a "Claim" as soon as possible, but in any event not later than five (5) days (24 hours in a case of Urgent Care), and tell you how to submit a proper claim for Prior Approval of treatment. However, you must at least provide your name,

medical condition and a description of the treatment requested before the Plan will be able to help you complete your claim.

(5) *Claims Made After Treatment*. If you make a Claim for benefits after you receive the treatment, and neither subsections (1) nor (2) above apply, your Claim will be decided within a reasonable time no longer than 30 days after receipt of your Claim. However, an additional 15 days may be needed if there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 30 days and told whether additional information is needed to decide your Claim. You will have at least 45 days to provide the additional information.

(6) *Disability Claims*. If you make a Claim for disability benefits, your Claim will be decided within a reasonable time but no longer than 45 days after receipt of your Claim. However, an additional 30 days may be needed if there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 45 days and told the requirements for receiving benefits, any unresolved issues, whether additional information is needed, and when a decision is expected. If you need to provide additional information, you will have at least 45 days to provide it.

(7) *Other Claims*. For all Claims for which the time frames in (a) through (d) above do not apply, a decision will be made within a reasonable time no longer than 90 days after receipt of your Claim. However, an additional 90 days may be needed if there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 90 days and stating when a decision is expected.

The time in which to make any Claim decision is extended during any time in which the Plan is waiting to receive requested additional information.

2. Contents of Claim Denials. If your Claim is denied, you will be provided in writing (via facsimile if you wish):

a. The specific reasons for the denial;

b. The date of service;

c. The name of the health care provider;

d. The claim amount (if applicable);

e. Notification that you may request, and the Plan will provide upon request, the diagnosis code and treatment code along with the corresponding meaning of such codes;

f. The reason for the denial, including any denial code, its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and, for a final denial notice, a discussion of the Plan's decision;

g. The Plan provisions on which the denial is based and any internal rules or guidelines that are not in the Plan, with copies of them;

h. Explanation of the scientific or clinical judgment for determination or a statement that such explanation will be provided free of charge upon request;

i. A list of any additional information needed to obtain approval of your claim, and why such information is needed;

j. If the denial relates to a claim involving urgent care, a description of the expedited review process applicable to such claim;

k. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

l. A reminder that these Claims and appeals procedures may be obtained from the Administrator for no charge, except for reasonable copy charges, and notice of your right to file a law suit under ERISA Section 502(a) if your appeal of the denial is denied; and

m. Information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman available to assist with internal claims and appeals and external review processes.

n. In addition, with respect to a claim for disability benefits, the denial will include:

(1) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

(2) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(3) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(4) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

3. Appealing a Decision. You have the right to appeal any adverse Claim decision. Please keep in mind that only where Preauthorization is required by the Plan or you have already received the service is there a "Claim" subject to these procedures.

a. For all Claims to which subsection (1)(d)(6) above applies, a written appeal may be filed within 60 days of notice of the Claim denial. You may submit any written records you wish to be reviewed and you may obtain copies of any related Plan records.

Your appeal will be decided by the next regularly-scheduled meeting of the Board of Trustees that is at least 30 days after your written appeal is received. If special circumstances require additional time to process your appeal, you will be notified of those circumstances and a decision will be made no later than the third meeting following receipt of your written appeal.

If your appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to specific plan provisions, and you may have access to all records that were used in reaching the decision.

b. For Claims made to which subsections (1)(d)(1) through (5) above apply, the following appeals procedures apply:

(1) You have 180 days to appeal a Claim denial. No deference will be given to the initial Claim denial. Your appeal will be decided by an individual(s) who did not take part in the Claim denial and who is not the subordinate of such a person.

(2) If your Claim involves a medical judgment, a health care professional trained in the relevant field will be consulted who did not take part in the Claim denial and who is not the subordinate of such a person. You may also request the names of medical professionals who gave advice on your Claim denial.

(3) For Urgent Care Claims, you may make a request for an expedited appeal, orally or in writing, and all necessary information may be exchanged by telephone, facsimile or other expeditious method.

(4) Appeals for Urgent Care Claims will be decided as soon as possible, but not later than 72 hours after receipt of the appeal.

(5) Appeals of Claims made before treatment will be decided within a reasonable period of time, but not later than 30 days.

(6) Appeals of Claims made after treatment will be decided by the next regularly scheduled meeting of the Board of Trustees that is at least 30 days after your written appeal is received. If special circumstances

require additional time to process your appeal, you will be notified of those circumstances and a decision will be made no later than the third meeting following receipt of your written appeal.

(7) If your appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to the specific plan provisions, and you may have access to all records that were used in reaching that decision.

If any internal rule, guideline, protocol, or other similar criterion was used in the appeal denial, you will be told about it and may have a copy of it; and, for disability claims, you will be told about it and may have a copy or will be told that such do not exist. If the denial is based on Medical Necessity or Experimental treatment, or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination.

For disability claims, this will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of change upon request. In addition, in the case of an adverse benefit decision with respect to disability benefits, the appeal denial will include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your appeal, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding you presented by you to the Plan made by the Social Security Administration.

You will receive, free of charge, any new or additional rationale and/or evidence considered, relied on, or generated by the Plan (or at the direction of the Plan) in connection with your claim. You will receive this rationale and/or evidence sufficiently in advance of the date on which the notice of the adverse benefit determination is required in order to give you a reasonable opportunity to respond prior to that date.

The appeal denial will also provide the following disclosure required by ERISA: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

The appeal denial will include information on your right to bring an action under Section 502 of ERISA. If you are not satisfied with the decision made on your appeal, you may file a lawsuit in federal court against the Plan. However, you must complete the appeal to the Trustees before you may file a lawsuit. You will have 90 days after completing

the appeals process, including any applicable external review as provided for in subsections (4) and (5) below, and being denied to file suit, after which your Claim will be waived. In the case of a plan providing disability benefits, the appeal denial will include a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

4. Standard External Review. You may request, in writing, an independent external review of certain claim denials. However, a claim denial that relates to your failure to meet the Plan's eligibility requirements does not entitle you to an external review.

a. *Request for External Review*. You may request an external review only after completing the Plan's internal claims and appeals procedures. You must request an external review within 120 days after the date that you receive the Plan's final written decision.

b. *Preliminary Review*. Within five (5) business days after receiving your request, the Plan will complete a preliminary review to determine whether:

(1) The denial determination is within the scope of the external review process because it involves (i) 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 its determination that a treatment is Experimental or investigational) or (ii) a rescission of coverage (whether or not the rescission has any effect on a particular benefit at that time);

(2) You are or were covered under the Plan at the time the health care item or service was requested or provided;

(3) Your claim denial does not relate to whether you meet the requirements for eligibility under the terms of the Plan;

(4) You have completed the Plan's internal claims and appeals process unless, under the regulations, you are not required to;

(5) You have provided all the information and forms required to process an external review.

Within one (1) business day after completing the preliminary review, the Plan will provide you with written notification. If your request is complete but not eligible for external review, the notification will include the reasons you cannot seek external review and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to complete your request. You may complete your request within the 120-day request period or, within the 48-hour period after you receive the notification, whichever is later.

c. *Referral to Independent Review Organization* – If it is determined that your request is eligible for external review, the Plan will assign an Independent Review Organization ("IRO") to conduct your external review. External reviews are randomly assigned to one (1) of the IROs that are contracted with the Plan. Within five (5) business days of referral to the IRO, the Plan will provide the IRO with any documents and information considered in denying your appeal.

d. *Independent Review*. The Plan will notify you in writing whether your request has been accepted for external review. This notice will inform you that you may submit in writing, within ten (10) business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review

The IRO will review all of the information and documents it receives within the time limit. In addition, the IRO will consider the following items, to the extent they are available and the IRO considers them appropriate:

(1) Your medical records;

(2) Your attending health care professional's recommendations;

(3) Reports from appropriate health care professionals and other documents submitted by you, your treating provider or the Plan;

(4) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

(5) Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering the information to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

e. *Notice of External Review Decision*. The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to you and the Plan. The decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claims (including the date or dates of service, the health care provider, the claim amount, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

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

(4) A discussion of the principal reason or reasons for its 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 determination is binding except to the extent that other remedies may be available under State or Federal law to either you or the Plan;

(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.

f. *Effect of Reversal of Plan's Decision* – If the IRO reverses the denial of your appeal, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

5. Expedited External Review.

a. *Request for Expedited External Review*. You may make a request for an expedited external review, if you receive:

(1) A claim denial that involves a medical condition for which the time for completing the expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, provided that you have also filed a request for an expedited appeal with the Plan; or

(2) A claim denial that has been upheld by the Plan, if you have a medical condition for which the time for completing the standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the claim denial concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but for which you have not been discharged from a facility.

b. *Preliminary Review* – Once the request is received, the Plan must immediately determine whether the request meets the reviewability requirements for standard external review. The Plan must immediately send you a notice that meets the requirements for standard external review of its eligibility determination.

c. *Referral to Independent Review Organization* – If it is determined that your request is eligible for external review, the Plan must assign an IRO pursuant to

the requirements for standard review. The Plan must provide all necessary documents and information considered in making the claim denial to the IRO.

d. *Independent Review*. The assigned IRO must consider the information or documents described in the standard review procedures, to the extent the information or documents are available and the IRO considers them appropriate.

e. *Notice of External Review Decision*. The IRO must provide notice of the final external review decision, in accordance with the requirements for standard review, within 72 hours after the IRO receives the request. If the notice is not in writing, within 48 hours after the date of providing notice, the IRO must provide written confirmation of the decision to you and the Plan.

E. **Records**. Because of the Deductible(s) required under the Indemnity Medical Plan, it is important that you and your Eligible Dependents keep a record of incurred expenses as well as the benefits received. If you incur expenses, please be sure that itemized bills for these services are submitted with your claim. These bills should fully identify:

1. the patient;

2. the Doctor;

3. the date of treatment;

4. the nature of the treatment or services provided;

5. the charges for such service; and

6. in the case of prescribed medicine, a statement from the pharmacy showing the nature and date of purchase, prescription number and the name of the Physician who issued the prescription.

F. **Claims Payments Made in Error**. If the Plan pays benefits for or on behalf of an Employee or Dependent, when the Employee or Dependent is not in fact eligible or entitled to the benefits or if the Plan otherwise mistakenly pays benefits, the Employee or Dependent will promptly reimburse the Plan in full for any such benefits so paid. The Trustees, in their sole discretion, may deduct or offset any such money from future benefits. If the Plan files any legal action against the Participant to recover any such benefits, the Participant will pay all attorneys' fees and costs of the Plan, whether or not such an action proceeds to judgment. Receipt of Plan benefits is consent and agreement by the ineligible person to such liability.

G. Other Rights and Limitations.

1. Exhaustion of Remedies. No legal or equitable action for benefits under this Plan shall be brought unless and until the claimant, in accordance with the foregoing Claims and Appeals procedures:

a. has submitted a written Claim for benefits;

b. has been notified that the Claim is denied (or the Claim is deemed denied);

c. has filed a written appeal for review; and

d. has been notified in writing that the denial of the Claim has been confirmed (or the claim is deemed denied on review)

If you are not satisfied with the decision made on your appeal, you may file a lawsuit in federal court (and possibly also in state court with respect to a QDRO) against the Plan. However, you must complete the appeal, including each and every issue on which any lawsuit is based, to the Board before you may file a lawsuit. No legal or equitable action may be brought against the Plan, the Trustees, the Union or any Contributing Employer or its delegate relating to any dispute over benefits under this Plan more than 90 days after a final decision under the claims and appeal procedures.

2. Trustee Discretion. The Trustees have the exclusive right, power and authority in their sole and absolute discretion, to administer, apply and interpret this health and welfare plan and all other documents that describe the Plan and Trust Fund. The Trustees may decide all matters arising in connection with the operation and administration of the Plan. Plan benefits shall be paid only if the Trustees, in their discretion, decide that a Participant is entitled to them. Except as described in these procedures, all determinations made by the Trustees with respect to any matter arising with regard to Plan benefits will be final and binding on all concerned. Any judicial review of any Trustee decision must be done in deference to the Trustees' decision. Without limiting the generality of the foregoing, the Trustees shall have the sole and absolute discretionary authority:

a. To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits reimbursed under the Plan;

b. To formulate, interpret and apply rules, regulations, interpretations, practices and policies necessary to administer the Plan in accordance with its terms;

c. To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;

d. To resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents; and

e. To process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Trustees with respect to any matter arising under the Plan and any other Plan document shall be final and binding on all parties.

H. **Alternative / Substitute Treatment Plan**. The Plan specifies certain types, levels and limitations of benefits. In addition to those specified in the Plan, the Board of Trustees may elect to provide benefits or services pursuant to a Board approved Alternative/Substitute Treatment Plan ("AST Plan"), for an eligible person. The Board will only authorize an AST Plan when the Board, in its sole and absolute discretion, based upon such medical and other information and advice the Board deems sufficient and appropriate, determines that such an AST Plan is Medically Necessary and appropriate and that such an AST Plan is both cost effective and less

costly to the Plan than treatment otherwise available under the Plan rules. If the Board elects to approve an AST Plan, it will do so only for as long as such services are Medically Necessary, appropriate and cost effective for the Plan, and that the total benefits paid for such services do not exceed the total benefits to which the claimant would otherwise be entitled under this Plan in the absence of an AST Plan. If the Board approves an AST Plan for an eligible Participant in one instance, it shall not be obligated to provide the same or similar plan for other eligible Participants in any other instance. Nor shall such election be construed as a waiver of the right of the Board to administer the Plan in strict accordance with the provisions of the Plan document and Plan rules and regulations. This provision is for AST Plans and is not a means of plan redesign, nor is it intended to be applied to authorize procedures that are not FDA approved or otherwise Experimental. It is not intended to be applied to Experimental, non-FDA approved or over-the-counter Drugs or medications.

I. **Amendment Procedures**. The Board of Trustees may amend this Plan at any time or from time to time through amendments adopted by a majority vote. This Plan may be modified or amended retroactively. Ordinarily, however, the Trustees will not exercise the power to amend the Plan retroactively unless it will increase benefits to the Participants.

1. A Plan amendment may be suggested or proposed by a Trustee or professional who works for the Plan.

2. The Trustees will consider and discuss the amendment at a meeting of the Board of Trustees, seeking input from the Trustees and the professionals who work for the Plan.

3. An amendment will be adopted upon vote by a majority of the Trustees. If the Trustees are deadlocked, the procedure for resolution of a deadlock will apply.

4. Participants will be notified of all such Plan changes within 60 days.

5. An amendment may be signed by the chair and co-chair of the Board of Trustees outside of regularly scheduled trust meetings, subject to approval of the Plan change during a trust meeting either before or after the amendment is signed.

6. The Plan may also be amended at any time it is restated in its entirety.

J. Assignment of Benefits.

1. All benefits will be paid by the Plan to the eligible Employee or to the healthcare provider as a courtesy to the patient upon receipt of written proof satisfactory to the Plan, covering the occurrence, character and extent of the event for which the claim is made. The Plan shall have the right to have its medical or dental consultant review any claim prior to its payment.

2. Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person; however, any eligible Employee may direct that benefits due him be paid to any institution in which he or his Eligible Dependent is hospitalized or to any provider of medical services or supplies in consideration for medical or Hospital services rendered or to be rendered. Such direction may be honored by the Plan as a courtesy to the patient but may not in any

event be deemed an assignment of rights or deemed to provide standing to such institution or provider to assert any claim in any cause or other tribunal against the Plan.

3. In case of assignment, the provider must submit all claims and related billing information as soon as possible. The failure to file claims promptly may result in immediate termination of the assignment and any rights of the provider to maintain a claim against the Plan for payment of benefits, which rights shall revert solely to the Plan Participant or Beneficiary.

4. Plan payments for benefits with respect to a Plan Participant will be made in compliance with any assignment of rights made by, or on behalf of, such Participant or a Participant's beneficiary as required by Nevada's Plan for medical assistance approved under title XIX § 1912 (a)(1)(A) of the Social Security Act (Medicaid).

5. Where payment has been made by the State under Medicaid for medical assistance in any case where the Plan has a legal liability to make payment for such assistance, payment for the benefits will be made in accordance with any State law that provides that the State has acquired the rights with respect to a Participant to such payment for such assistance.

K. **Incompetent Individuals**. In the event the Plan determines that the eligible Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the eligible Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the eligible Employee, pay any amount otherwise payable to the eligible Employee, to the spouse, or to a relative by blood of the eligible Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto. In the event of the death of the eligible Employee before all amounts payable under the Plan have been paid, the Plan may pay any such amount to any person or institution determined by the Plan to be equitably entitled thereto. The remainder of such amount shall be paid to one (1) or more of the following surviving relatives of the eligible Employee: lawful spouse, child or children, mother, father, brothers or sisters, or to the eligible Employee's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

L. **Limitation of Rights**. No eligible Employee, Eligible Dependent, Beneficiary or other person shall have any right or claim to benefits under the Plan, or any right or claim to payments from the Plan, other than as specified in this Plan booklet, the applicable agreements and the provisions of the Trust Agreement. Any dispute as to eligibility, type, amount or duration of such benefits, or any right or claim to payments from the Plan, shall be resolved by the Board of Trustees in its sole, absolute and complete discretion, or its Agent, under and pursuant to the Plan, and its decision of the dispute, right or claim shall be final and binding on all parties thereto. "Agent" includes any insurance company, insurance service, third-party administrator or similar organization selected by the Board of Trustees to pay the benefits provided by the Plan.

M. **Right to Examination**. The Plan, at its own expense, shall have the right and opportunity to examine the person of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms and methods of administration and procedure, will be solely determined by the Plan.

N. **Effect on Workers' Compensation**. The benefits provided by this Plan are not in lieu of, and do not affect any requirement for, coverage by Workers' Compensation insurance laws or similar legislation.

O. **Controlling Documents**. The provisions of this Plan booklet are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan booklet and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

P. **Limit of Liability**. None of the benefits provided by the Plan are insured by any contract of insurance (except as specifically stated herein and except that the Board of Trustees has purchased stop-loss insurance from an insurance company to insure the Trust against various anticipated exposures to liability), and there is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the Plan collected and available for such purpose or that covered by the stop-loss insurance.

Q. **Limitation of Benefits**. It is recognized that the benefits provided by the Plan can be paid only to the extent that the Plan has available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the Contributing Employer to make Contributions as stipulated in its Collective Bargaining Agreement. In the event that any time the Plan does not have sufficient assets to permit continued payments hereunder, nothing contained in the Plan shall be construed as obligating any Contributing Employer to make benefit payments or contributions (other than the Contributions for which the Contributing Employer may be obligated by his Collective Bargaining Agreement) in order to provide the benefits established hereunder. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Contributing Employer, Union, associations, or any other persons or entity of any kind to provide the benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

R. **Secondary Coverage**. Participants who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Participant incurring costs that are not covered by the Plan and that would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

A provider that accepts the payment from the Plan will be deemed to consent and agree that (1) such payment shall be for the full amount due for the provision of services and supplies to a Participant and (2) it shall not "balance bill" a Participant for any amount billed but not paid by the Plan.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 14. INFORMATION REQUIRED BY ERISA AND OTHER APPLICABLE LAWS

A. **Statement of ERISA Rights**. As a Participant in the Teamsters Local 631 Security Fund for Southern Nevada, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

1. Examine, without charge, at the Administrative Office and at other specified locations such as work sites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

2. Obtain, upon written request to the Board of Trustees, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Board of Trustees may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of this summary annual report.

4. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

5. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Contributing Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA. If your Claim for a health and welfare benefit is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision without charge. You have the right to have the Plan review and reconsider your Claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 Board of Trustees 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 Board of Trustees. If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay

these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of Employee Benefits Security Administration.

B. **Termination of Trust Provisions**. This Plan 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 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.

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 greater group coverage than that contemplated by the Plan or Plans.

In no event shall any of the Plan's trust funds, except for benefits due, revert to or be recoverable by any Participant, Contributing Employer or Union.

C. **Mothers and Newborns**. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

D. **Women's Cancer Rights**. Under Women's Health and Cancer Rights Act of 1998, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a Participant or Beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Physician and the Patient, for:

1. all stages of reconstruction of the breast on which the mastectomy was performed;

2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be subject to annual Deductibles and Coinsurance provisions under the Plan. If you have any questions about Plan coverage of mastectomies or reconstructive surgery, please contact the Claims Office listed in the Quick Guide to Important Contacts.

E. **Mental Health Parity**. This Plan complies with Federal law, which generally does not permit annual or lifetime dollar limits for mental health benefits to be lower than those that apply to medical benefits. The Plan shall be interpreted consistently with such legal requirements. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that the financial requirements for coinsurance and copayments as well as other quantitative and qualitative limits for mental health and substance use disorder conditions must be no more restrictive than those requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these requirements on mental health and substance use disorder benefits.

F. **Privacy Practices**. The Trustees and appropriate professionals retained by the Plan, may, to the extent necessary and in accordance with federal and state privacy laws (to the extent applicable) and the Plan's HIPAA Policies and Procedures, have access to such personal health information regarding Participants and Beneficiaries as is reasonably necessary to make eligibility, payment, claims and appeals decisions, or as otherwise necessary to the administration of the Plan.

The Trustees shall develop HIPAA Policies and Procedures in accordance with applicable laws, and shall furnish to each Participant and Beneficiary a Notice of Privacy Practices. Such policies and practices shall be consistent with applicable federal and state laws.

The following are permitted and required uses and disclosures of Personal Protected Health Information ("PHI"), as that term is defined in the applicable laws, that may be made by the Plan sponsors, the Board of Trustees.

The Board of Trustees may make the following permitted and required disclosures of Personal Protected Health Information. All disclosures shall be of the Minimum Necessary information, as that term is defined under applicable law, except in the case of subsection (2) below.

1. *Permitted Disclosure Purposes*.

   a. As necessary for claims payment, Plan operations and treatment, including for the purpose of deidentifying information for further permitted disclosure.

   b. Determining eligibility and amount of benefits.

   c. Determining Medical Necessity, utilization reviews, and precertifications.

   d. Coordination of benefits.

e. Processing claims, auditing claims, investigating claims, responding to Participant inquiries regarding claims, and insuring proper claims payment.

f. Subrogation and other third-party recovery processing.

g. Determining proper Contributions.

h. Processing and determining stop loss coverage.

i. Claims and appeals processing.

j. Quality assessment, Case Management, provider rating, underwriting and premium rating and other related activities.

k. Legal and auditing services, including plan compliance.

l. Plan design analysis, including cost analysis and plan change evaluations.

m. Implementation of applicable law and other applicable laws.

n. Tax and other regulatory filings.

2. *Permitted or Required Disclosures*.

a. Disclosures to the covered individual.

b. Disclosures that are subject to a specific written authorization from the covered individual.

c. Uses that are incident to a use or disclosure otherwise permitted or required by law.

d. To the covered individual, when requested, to the extent required by law.

e. To the Secretary of Health and Human Services, when requested.

3. *Other Compliance*. Further, the Board of Trustees will—

a. Not use or further disclose the information other than as permitted or required by the Plan and HIPAA Policies and Procedures, or as required by law.

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

c. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

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

e. Make available PHI in accordance applicable law.

f. Make available PHI for amendment by Participants and Beneficiaries and incorporate any amendments to PHI in accordance with applicable law.

g. Make available the information required to provide an accounting of non-routine disclosures in accordance with applicable law.

h. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated for purposes of determining compliance by the Plan with the regulations requiring the Plan's HIPAA Policies Procedures and this Part 14.G.

i. To the extent feasible, return or destroy all PHI received from the Plan that the Trustee(s) still maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

j. Ensure the adequate separation required by the following: The Board of Trustees and the Plan shall be treated as separate and distinct entities for purposes of these privacy rules. To that end, only the Administrative Office shall be authorized by the Trustees to have access to Protected Health Information and such access shall be solely for the specific Plan-related functions performed by such persons or entities.

4. *Noncompliance*. In the event any person or entity to which the Plan has provided Protected Health Information uses or discloses such information in a manner inconsistent with the Plan, its HIPAA Policies Procedures, or applicable law, the Trustees shall have the right to:

a. Notify such person or entity in writing of such violation and demand immediate correction and remedial measures be taken to correct such use or disclosure.

b. Assess against such person or entity the actual costs of the corrective or remedial action.

c. Send a letter of reprimand to any such person or entity that repeatedly commits such violations.

d. Take such additional appropriate action including, to the extent feasible, terminating the Fund's relationship with such person or entity, or reporting such violations to the Secretary of Health and Human Services.

5. *Security of ePHI*. The Trustees shall (1) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information ("ePHI") (if any)

that they create, receive, maintain or transmit on behalf of the Plan; (2) ensure that the adequate separation required between the Trustees and the Plan is supported by reasonable and appropriate security measures; (3) ensure that any agent, including a subcontractor to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and (4) report to the full Board of Trustees any security incident of which any Trustee becomes aware. It is expected, however, that no Trustee shall engage in any of the aforementioned activity with regard to ePHI.

G. **Family and Medical Leave**.

1. The Family and Medical Leave Act ("FMLA") requires some employers to give their employees up to 12 weeks of unpaid leave during any 12-month period for certain family and medical reasons. During FMLA leave, you may continue coverage for medical, prescription and dental benefits under the Plan provided that your Contributing Employer continues to pay the required Contributions for you and you continue to pay any required employee Contributions.

2. FMLA permits a spouse, son, daughter, parent or next of kin to take up to 26 weeks of leave to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, therapy, in outpatient status, or is otherwise on a temporary disability retired list, for a serious injury or illness. An employee is permitted to take FMLA leave for any "qualifying exigency" (as defined by the Secretary of Labor) arising out of the fact that the spouse, son, daughter, or parent of the employee on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

3. Whether you are entitled to FMLA leave is determined by your employer and your union, not by the Plan. If you are not receiving paychecks while on FMLA leave you must make arrangements with your employer and/or union to ensure that Contributions to the Plan are made on your behalf. Any disputes regarding entitlement to leave with continuing medical benefits must be resolved by the Contributing Employer and the Association.

4. When you return to work your benefits will be reinstated as though you had not taken leave. If you do not return to work after taking FMLA leave:

   a. Your coverage will end on the date you give notice that you are not returning to work;

   b. You may be required to repay your employer the cost of the coverage you had while on leave (unless you do not return to work because of a serious medical condition beyond your control); and

   c. You may be eligible for COBRA (explained in Part 5.A).

5. FMLA leave will not cause you to lose any accumulated benefits. For more information on your employer's and union's FMLA and other leave policies, please call your employer or your union.

H. **Reduction of Benefits**. The Trustees have authority to adjust and/or reduce benefits available to Employees on whose behalf Contributions are insufficient to cover the full current cost of benefits, as determined in the sole and complete discretion of the Trustees. Such an adjustment and/or reduction may include but is not limited to elimination of dental or any other item of coverage, higher Deductibles, Copays, etc. The basis for such an adjustment and/or reduction may include, but is not limited to, the failure of a negotiated Contribution rate to keep pace with the cost of benefits, or an Employee's failure to pay, or authorize his employer to transfer the Employee's portion of Contributions.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

PART 15. SOME DETAILS ABOUT THE PLAN AND THE TRUSTEES

A. **Name of the Plan**. This Plan is known as the Teamsters Local 631 Security Fund for Southern Nevada.

B. **Name, Address and Telephone Number of Plan Sponsor**. This Plan is sponsored and administered by a joint labor-management Board of Trustees pursuant to an Agreement and Declaration of Trust. The name, address, and telephone number of the Board of Trustees is:

Board of Trustees
Teamsters Local 631 Security Fund for Southern Nevada
BeneSys Administrators
8311 W. Sunset Road, Suite 250
Las Vegas, NV 89113
(702) 415-2185
(877) 304-6702
www.teamsters631benefits.org

C. Name and Address of Agent for Service of Legal Process.

Bryce C. Loveland
Brownstein Hyatt Farber Schreck, LLP
100 North City Parkway, Suite 1600
Las Vegas, Nevada 89106-4615

In addition, service of legal process on the Plan may be affected by service of process on BeneSys Administrators, the Board of Trustees or on any Trustee at his address listed below.

D. Plan Administrator and Type of Administration. The Plan's administrator is the Board of Trustees. The type of administration is jointly trusteed labor-management trust fund. Day-to-day administrative functions are performed by BeneSys Administrators.

E. Name, Title and Principal Place of Business for Each Trustee.

Employer Trustees

Patrick Velasquez (Co-Chairman)
Nevada Contractors Association
150 N. Durango Drive, Suite 100
Las Vegas, Nevada 89145

Thomas Brodeur
Freeman Companies
6555 West Sunset Road
Las Vegas, NV 89118

Union Trustees

Tommy Blitsch (Co-Chairman)
Teamsters Local 631
700 North Lamb Boulevard
Las Vegas, NV 89110

Noelle Cutting
Teamsters Local 631
700 North Lamb Boulevard
Las Vegas, NV 89110

Brent Conrad
Werdco BC, Inc.
4660 Flippin Street
Las Vegas, NV 89115

Javon Jefferson
Teamsters Local 631
700 North Lamb Boulevard
Las Vegas, NV 89110

Bill Muller
Nth Degree
4545 Cameron Street, Suite B
Las Vegas, Nevada 89103

Kenny Taber
Teamsters Local 631
700 North Lamb Boulevard
Las Vegas, NV 89110

Lance Metha (Alternate)
Las Vegas Paving Corp.
3401 North 5th St.
Las Vegas, NV 89032

Miguel Avalos (Alternate)
Teamsters Local 631
700 North Lamb Boulevard
Las Vegas, NV 89110

F. **Identification Numbers, Type of Plan, Plan Year**. The taxpayer identification number assigned to the Board of Trustees by the Internal Revenue Service is EIN 88-0231734. The Plan Number assigned to the Plan by the Board of Trustees is 501.

This Plan is a health and welfare plan providing life insurance, Accidental Death and Dismemberment insurance, dental, Hospital, medical and Prescription Drug benefits. The Plan year for this Plan is a 12-month period beginning May 1 and ending the following April 30 and is the fiscal year of the Plan for the purpose of accounting and all reports to the U.S. Department of Labor and other regulatory agencies.

Note: Except for the fully insured death and Accidental Death and Dismemberment benefits, the prepaid dental benefits, no other benefits provided by the Plan are insured by any contract of insurance, and there is no liability on the Board of Trustees or any individual or entity to provide payment over and above the amounts collected by the Plan and available for such payment.

G. **The Plan's Source of Funding and Contributions**. The Plan is maintained by Teamsters Local 631 Security Fund for Southern Nevada and Contributing Employers who are parties to Collective Bargaining Agreements ("CBA") requiring Contributions to the Teamsters Local 631 Security Fund for Southern Nevada. The CBAs generally provide that the Contributing Employers will make monthly Contributions to the Teamsters Local 631 Security Fund for Southern Nevada for the purpose of enabling eligible Employees working under the CBAs to participate in the Teamsters Local 631 Security Fund for Southern Nevada.

The Contribution rates and the job classifications covered are specified in the CBAs. The Plan is funded by these Contributions (certain Participants and Dependents whose coverage would otherwise terminate may continue coverage for a limited period of time by Self-Paying the required Contributions).

Copies of CBAs are available for examination, without charge, by Participants and Beneficiaries at the Administrative Office or the Local 631 Union Hall, and may also be obtained upon written request addressed to the Plan. Copying charges may apply.

Information on whether a particular Contributing Employer is making Contributions, and if so, the address of the Contributing Employer, may be obtained by Participants and Beneficiaries without charge upon written request to the Board of Trustees at the Administrative Office.

H. DEFINITIONS.

1. "Accident" means an unexpected, external, unusual, unforeseen, or unlooked for event or happening resulting in injury or losses.

2. "Accidental Death and Dismemberment" ("AD&D") means certain losses, including but not limited to dismemberment or death as a result of an Accident.

3. "Active Employee" means any person who qualifies as an "employee" under the Labor-Management Relations Act and (a) who is performing Covered Employment for a Contributing Employer, or (b) on whose behalf there exists a written obligation to contribute to the Plan without regard to the performance of such duties. Such employment does not alone make an individual eligible for benefits. An individual must meet the Plan's eligibility requirements to be eligible for benefits.

4. "Administrative Office" or "Administrator" means the third party with which the Board of Trustees contracted to handle the day-to-day operations of the Plan.

5. "Allowable Expense" means the rate, amount, or schedule on which the Plan's payment for covered services and supplies is based. Allowable Expenses are subject to Deductibles, Copayments, Coinsurance, and Plan limits. The Plan pays no more than the Allowable Expense or the actual billed charges, whichever is less. However, the amount actually paid by the Plan may be a percentage of the Allowable Expense. The Plan has the sole, complete and final authority and discretion in determining Allowable Expense. Allowable Expense is determined according to the following method:

    a. Network Provider Services: Except as specified in immediately below or as may be otherwise specified in the Plan, to the extent benefits are paid pursuant to a PPO Agreement or Contract between the Plan and a provider, the Allowable Expense is the rate, amount, or schedule stated in such Agreement or Contract. If a Participant is receiving certain types of treatment from an In-Network Provider, and the Provider becomes Out-of-Network, the Plan will permit the Participant to elect to continue treatment for the duration of the treatment, or 90 days, whichever is earlier, at the same cost-sharing requirements applicable to when the Provider was In-Network, in accordance with federal law and regulation.

    b. Non-Network Provider Services: Except as specified immediately below or as may be otherwise specified in the Plan, for covered services and supplies provided by a Non-Network Provider, the Allowable Expense is (1) the negotiated rate between the Plan and the provider, or (2) the Plan's rate or schedule, or percentage thereof, for such covered services or supplies, whichever is less, as determined in the sole, exclusive, and final judgment of the Plan.

    c. Fully Contracted Hospital and Step Down Facility Services: For Hospital, step down facility, and related services and supplies covered by contracts with the Health Services Coalition rendered or delivered by a Network Provider, the

Allowable Expense is the rate, amount, or schedule stated in the applicable contract with the Health Services Coalition ("HSC").

d. Non-Network Emergency Services. For Non-Network Emergency Services, the cost-sharing requirement is determined by either (a) the amount that the state approves under the All-Payer Model Agreement for the item or service; (b) if in a state with no All-Payer Model Agreement, the amount specified under state law if applicable; or (c) if no state law applies, the amount of the Qualifying Payment Amount. The Qualifying Payment Amount is determined in accordance with applicable federal law and regulation.

e. Contracted Hospitals and Their Outpatient Departments, and Ambulatory Surgical Centers with Non-Network Provider. For a Non-Network Provider in a contracted Hospital, including its outpatient department, or in an ambulatory surgical center, the cost-sharing requirement is determined in the same manner as Non-Network Emergency Services described above. If the Non-Network Provider provides a valid Participant waiver to the Plan, the regular out-of-network benefit coverage rates apply and the Non-Network Provider will be able to balance bill the Participant.

f. Non-Network Air Ambulance Services. For Non-Network air ambulance services, the cost-sharing requirement is determined using the lesser of the amount determined in the same manner as Non-Network Emergency Services or the billed amount for services.

g. Hospital and Step Down Facility Services with Non-Contracted Provider Inside Nevada: Except as stated in the foregoing paragraph (d), for an HSC Service rendered or delivered by a non-HSC Network Provider within the Nevada geographical area serviced by the HSC, the Allowable Expense is the lowest HSC-contracted rate, amount, or schedule, or percentage thereof or such other rate, amount, schedule or percentage that is the lowest "reasonable amount" that complies with the requirements of Section 2719A of PPACA and related federal guidance, as determined in the sole, exclusive and final judgment of the Plan;; provided, however, to facilitate the transition of a provider from contracted status to non-contracted status, the Plan in its sole and absolute discretion, may utilize any available wrap network for a limited period.

h. Hospital and Step Down Facility Services with Non-Contracted Provider Outside of Nevada: Except as stated in the foregoing paragraph (d), for Hospital, step down facility and related services and supplies rendered or delivered outside the Nevada geographical area serviced by the HSC, and not subject to any PPO Agreement or Contract, the Allowable Expense is the negotiated, discounted, or other rate, amount, or schedule, whichever is less, or such other rate, amount, schedule or percentage that is the lowest "reasonable amount" that complies with the requirements of Section 2719A of PPACA and related federal guidance, as determined in the sole, exclusive, and final judgment of the Plan.

i. Non-Network Provider Ground Ambulance Services: For ground ambulance services provided by non-contracted providers, the Allowable Expense is determined as follows: (1) under the Indemnity PPO plan and the EPO Plan for

Active Employees and Pre-Medicare Retirees, the Allowable Expense is the usual, customary and reasonable rate as determined by the Plan in its sole and absolute discretion, and (2) under the EPO Plan for Medicare Retirees, the Allowable Expense equals the allowable amount for such service under Medicare.

6. "Bank" or "Dollar Bank" means a type of recordkeeping account that tracks either all dollars or all hours, as specified, credited for an Active Employee's work for one (1) or more Contributing Employers.

7. "Bargaining Unit Employees" means those persons covered by a Collective Bargaining Agreement that requires Contributions to this Plan.

8. "Behavioral Health Services" means services, supplies, and/or treatments rendered by participating providers that are related to the diagnosis and/or treatment of behavioral disorders, mental illness, substance abuse and/or addiction, as such disorders, illnesses, conditions, and addictions are defined by the Plan or its designee, in their sole discretion.

9. "Beneficiary" means the person you name to receive death or Accidental Death and Dismemberment benefits when you die. You may name anyone as your Beneficiary and you may change your Beneficiary at any time.

10. "Board of Trustees" or "Trustees" means the persons designated in the Trust Agreement together with their successors designated and appointed in accordance with the terms of the Trust Agreement.

11. "Calendar Year" means January 1 through December 31 of each year.

12. "Case Management" means a program administered by the Plan or its designee, whereby medical professionals work with you, family/caregivers, Physicians, and other healthcare providers to coordinate and develop a timely and cost effective treatment plan.

13. "Chronic" means a disease or condition that develops slowly and persists over a long period of time.

14. "Consolidated Omnibus Budget Reconciliation Act of 1985" ("COBRA") means the federal law by which you and your Eligible Dependents may continue to receive medical benefits available under the terms of the Plan after you and your Eligible Dependents no longer satisfy the Plan's eligibility requirements, provided that you and your Dependents would lose coverage to satisfy the criteria for COBRA eligibility.

15. "Coinsurance" means the percentage of Allowable Expenses that you must pay to a provider for eligible services.

16. "Collective Bargaining Agreement" or "CBA" means an agreement in effect between the Contributing Employer and the Teamsters Local 631 and any other collective bargaining agreement that provides for the provision of benefits under the Plan. The relevant provisions in the CBA determine the rate at which Contributing Employers contribute to the Plan and you on whose behalf Contributions are made, subject to the Fund's minimum participation standards.

17. "Continued Stay Review" means the review of a Hospital admission or other service to ensure Medically Necessary and appropriate care is delivered during a facility stay.

18. "Contributing Employer" means an employer that is required to make Contributions for health and welfare benefits to this Plan under the terms of a Collective Bargaining Agreement or other written agreement requiring Contributions to this Plan.

19. "Contributions" means money paid to the Plan on your behalf by your Contributing Employer each month to pay for your Plan benefits. The Collective Bargaining Agreement between your Contributing Employer and your Union requires your Contributing Employer to make Contributions to the Plan.

20. "Copayment" or "Copay" means the dollar amount that you or your Eligible Dependents must pay directly to a provider out of your own pocket at the time services are rendered when accessing certain benefits available under the Plan, as set forth in the Quick Guide to Benefits and other related Plan materials.

21. "Coordination of Benefits" ("COB") means the payment policy of the Plan that states how benefits will be paid if employees or dependents are covered under this Plan and another health plan, and/or how benefits will be paid if they have dual coverage under this Plan.

22. "Cosmetic Surgery" means any surgery or procedure primarily for the improvement of physical appearance or changing or restoring bodily form without materially correcting bodily malfunction.

23. "Covered Employment" means—

    a. employment in a job classification covered by a Collective Bargaining Agreement, requiring Contributions to this Plan; or

    b. employment by a local union, an association, an employer, or the Trustees in a non-Bargaining Unit Employee capacity for which Contributions to the Plan are permitted and required in writing by the Trustees.

24. "Deductible" means the amount that is payable by a Participant as listed in the Quick Guide to Benefits. Some Deductibles apply once each Calendar Year and some Deductibles are applied when you use health care services. See Part 6.D for additional information on Deductibles.

25. "Dentist" means an individual who is licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license.

26. "Dependent" or "Eligible Dependent" means an individual who qualifies for coverage under the Plan as a result of his relationship to a Participant, including but not necessarily limited to legal spouse, children and adopted children as discussed in Part 1.C. For the avoidance of doubt, an Employee is permitted to be a dependent to a Retiree spouse who has coverage as a Retiree and a Retiree is permitted to a be a dependent to an Employee spouse who has coverage as an Active Employee.

27. "Drug" means any article that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, only upon written or oral prescription of a Physician, licensed healthcare practitioner or Dentist licensed by law to administer it.

28. "Durable Medical Equipment" means medical equipment that can withstand repeated use, 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 nondurable.

29. "Eligible Individual" means each Active Employee and Retired Employee and each of their Eligible Dependents, if any, unless specifically excluded. With regard to special coverage provisions, such as COBRA or military continuation coverage, or the like, the term "Eligible Individual" in those sections refers to a person who is eligible for such special coverage.

30. "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 a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

31. "Emergency Services" means, with respect to an Emergency Medical Condition— (a) a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (b) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient. Certain post-stabilization services will also be considered Emergency Services unless the provider determines that the patient may travel via nonmedical or nonemergency medical means to an available In-Network Provider in accordance with federal law and regulation.

32. "Employee" means an employee of a Contributing Employer or Union who is covered under the Plan pursuant to the terms of the eligibility rules.

33. "Employee Retirement Income Security Act of 1974" ("ERISA") means the legislative act defining the fiduciary responsibilities of the people engaged in the administration, supervision and management of welfare and pension plans. The act also gives specific rights to the participants of welfare and pension plans.

34. "Enrollment" means the process by which Eligible Individuals may enroll themselves and any Dependents in the Plan for the purposes of coverage under the Plan by completion of an Enrollment form or such documents as the Board of Trustees may, in their discretion, require, which must be received by the Plan or its authorized designee prior to an Eligible Individual's coverage by the Plan.

35. "EPO Provider" means a Hospital, Outpatient Facility, Physician or other healthcare provider that has a contract with the Plan's EPO network to provide care and treatment at a specified rate to Participants of the Plan enrolled in the EPO option.

36. "Essential Health Benefits" means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations, as may be amended from time to time. Essential Health Benefits include at least the following general categories and the items and services covered within these categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including Behavioral Health Services; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and Chronic disease management; and pediatric services, including oral and vision care.

37. "Experimental" means any procedures, devices, services, Drugs, or medicines, or the use thereof, which is: considered by any governmental agency to be unproven, Experimental, or investigational; or is not covered under Medicare reimbursement laws, regulations, or interpretations, or schedules; or is not in accordance with the commonly and customarily recognized principles of medical practice in the United States at the time practiced; or that is recognized by the organized medical community in the United States as Experimental or investigational; or does not constitute an effective treatment for the nature of the diagnosed illness, injury or condition being treated, as determined by the Trustees or the medical director or medical consultant retained by the Plan in accordance with the Plan's procedures for determining Experimental or investigational procedures, as well as the Plan's definition of Medical Necessity.

38. "Family Medical Leave Act" ("FMLA") means the legislative act governing the rights of employees to continued coverage during certain leaves of absence from work due to certain family and medical events.

39. "He" and "His" have the same meaning as "She" and "Her" as used in this Plan document.

40. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

41. "Home Health Care" means intermittent Medically Necessary skilled health care services delivered in the home of a Participant under orders of a Physician that are provided to Participants for medical reasons and who are physically unable to obtain necessary medical care on an outpatient basis.

42. "Hospice" means an organization that provides a coordinated set of services rendered at home or in outpatient or institutional settings for the Eligible Individual who is suffering from a disease or condition with a terminal (within six (6) months) prognosis.

43. "Hospice Care Program" means a program of care that offers 24-hour services to terminally ill patients in the home, on an outpatient basis and/or on a short-term inpatient basis, and includes such services and items as nursing care, Physical/occupational therapy, medical social services, home health aid, medical supplies, Physician services, short-term inpatient care and counseling for the patient and his family.

44. "Hospital" means a legally operated institution that is either—

a. accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals; or

b. supervised by a staff of Doctors, has 24-hour-a-day nursing service and is primarily engaged in providing either—

(1) general inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or

(2) specialized inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself is qualified under (a) or (b) of this definition) or with a specialized provider of these facilities.

In no event will the term "Hospital" include a nursing home or an institution or part of one that (a) is primarily a facility for convalescence, nursing, rest, the aged, or for care of drug addicts or (b) furnishes primarily domiciliary or custodial care, including training in daily living routines, or (c) is operated primarily as a school.

45. "Hospitalist" means a Physician who tends to patients while in the Hospital to coordinate and oversee care during the admission. A "Designated Hospitalist" is a Physician that is presented to a Participant for the purposes of overseeing and coordinating care. A "Non-Designated Hospitalist" is a Physician that is chosen by a Participant to oversee his or her care after the Participant refuses the services of a Designated Hospitalist. If a Participant is presented with a Designated Hospitalist that is not providing services as part of the Hospitalist Program, and is notified by a Plan representative that the physician is not part of the Hospitalist Program, that physician will then become a Non-Designated Hospitalist as of the date of notice. If the Participant refuses to switch to a Designated Hospitalist that provides services as part of the Hospitalist Program, the Participant will be responsible for 100% of the billed charges going forward after the date of notice.

46. "Hospitalist Program" means the program that provides Hospital inpatient Physician services to Participants. The Hospitalist Program is mandatory for inpatient primary Physician care. The Hospitalist Program utilizes licensed nonspecialist Hospital-based Physicians who have directly contracted with the Plan or with the Health Services Coalition on behalf of the Plan. Use of Hospitalist Program Physicians for inpatient care is required for all Participants. Participants receiving care through the Hospitalist Program will have no out-of-pocket expenses such a Deductibles, Coinsurance and Copays for the covered services by Hospitalist Program Physicians. Participants who refuse care under the Hospitalist Program are responsible for 100% of the billed charges by the non-Hospitalist Program Physicians. Physician care by specialists such as OB/GYN and Pediatricians will continue to be covered and paid as normal under the Plan rules, since specialists are not part of the Hospitalist Program.

47. "Indemnity Medical Plan" means the option providing the medical benefits described in Part 7 that are self-insured by the Fund.

48. "Maximum Benefit" refers to the maximum amount payable per person for the specified service or benefit as shown in the Quick Guide to Benefits.

49. "Medically Necessary" and "Medical Necessity" means services and supplies that are determined by the Plan, through its retained health care professionals, to be:

    a. appropriate and necessary for the symptoms, diagnosis or direct treatment of an illness or injury;

    b. not Experimental;

    c. within the standards of good medical practice within the organized medical community;

    d. not primarily for the convenience of the Participant, the Participant's Physician or any other provider; and

    e. the most appropriate supply or level of service that can be safely provided.

50. "Medicare" means Parts A and B of Title XVIII of the Social Security Act (Federal Health Insurance for the Aged), U.S. Public Law 89-97, and any amendments.

51. "Member Assistance Plan" ("MAP") means the organization contracted by the Plan to provide services for emotional, mental, and nervous and substance use disorders.

52. "Network Provider" means a Hospital, Outpatient Facility, Physician or other healthcare provider that has a contract with the Plan's EPO or PPO network to provide care and treatment at a specified rate to Participants of the Plan.

53. "Non-EPO Provider" means a provider that does not have a contract to provide services at a preferred rate to Participants of the Plan enrolled in the EPO option.

54. "Non-Network Provider" means a provider that does not have a contract to provide services at a preferred rate to Participants of the Plan, for which health benefits may be payable under the Plan subject to the applicable Deductible and reduced payment percentages or limitations.

55. "Non-PPO Provider" means a provider that does not have a contract to provide services at a preferred rate to Participants of the Plan enrolled in the PPO option.

56. "Nurse" means, as applicable, a Registered Nurse.

57. "Open Enrollment" means the regularly scheduled period of time when eligible Employees may change from one (1) plan to another.

58. "Participant" means an Employee, Retiree or Dependent who is eligible for benefits under the applicable standards in the Plan.

59. "Physician" or "Doctor" means a Physician licensed as a Medical Doctor (M.D.), Osteopath (D.O.), Podiatrist (D.P.M.), Chiropractor (D.C.), Dentist (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Psychiatrist (M.D. or D.O.), Physician Assistant (P.A.),

Physical Therapist (P.T.), and Certified Registered Nurse Anesthetists (C.R.N.A.), Nurse Practitioner (N.P.), Speech Therapist (S.T.), Occupational Therapist (O.T.) and Certified Nurse Midwife (C.N.M.), practicing within the scope of their license.

A Physician or Doctor, for purposes of the Psychiatric Care/Substance Use Disorder Treatment Program benefit only, shall include any licensed psychologist, psychiatrist, or clinical social worker. The term shall include other Behavioral Health Service providers if approved by the Behavioral Health Services Medical Services Review organization, such as a marriage, family and child counselor, or a mental health Nurse working individually or within a corporation, clinic or group practice.

Note: services rendered by a Dentistv are reimbursable under the Dental Plan provisions only, except as described under Dental and Oral Surgical Services of the Medical Plan.

The terms "Physician" or "Doctor" shall not include the Employee or his Dependents or any person who is the spouse, parent, child, brother or sister of such Employee or Dependent.

60. "Plan" means the Teamsters Local 631 Security Fund for Southern Nevada as created and established pursuant to the Agreement and Declaration of Trust and any amendment(s) thereto.

61. "Preferred Provider Organization" ("PPO") means the health benefits payable under the Plan for services received from providers that have contracted with the Plan's PPO network to provide services at generally discounted rates.

62. "PPO Provider" means a Hospital, Outpatient Facility, Physician or other healthcare provider that has a contract with the Plan's PPO network to provide care and treatment at a specified rate to Participants of the Plan enrolled in the PPO option.

63. "Prescription Drug" means a prescription medicine that to be dispensed requires, by Federal or State law, a written prescription of a Physician or healthcare practitioner, Dentist, or Podiatrist. Prescription Drug shall include insulin and diabetic supplies (syringes, chem strips and lancets).

64. "Prior Authorization" or "Preauthorization" means the requirement that the Plan or its designee be provided with justification, as a condition of coverage and reimbursement by the Plan, that the delivery of particular services, supplies, and/or medications to you or your Dependents is Medically Necessary and appropriate for the diagnosis given, prior to the actual provision of such services, supplies, and/or medications. The Plan or its designee may, from time to time, amend categories and specific medical services, supplies, and/or medications that require Prior Authorization under the Plan. Payment for any health care service or procedure will be determined on the basis of the plan of benefits in effect at the time the service or procedure is performed regardless of any Prior Authorization. Prior Authorization does not mean that benefits are guaranteed or payable or that the particular service is a benefit covered by the Plan. It means only that the service has been approved as Medically Necessary and appropriate.

65. "Prosthetic" means an artificial appliance or device designed to replace all or part of a body part and used to alleviate a body defect, including but not limited to, artificial limbs, heart pacemakers, the initial pair of corrective lenses needed after cataract surgery.

66. "Qualified Medical Child Support Orders" ("QMCSO") means a legal document issued by a court or other agency that orders an Employee covered under the Plan to enroll a child as a Dependent.

67. "Qualifying Payment Amount" means the plan's median contracted rate for an item or service, which is the middle amount in an ascending or descending list of contracted rates for similar items or services, adjusted for market consumer price index in urban area, developed in accordance with federal statute and regulation.

68. "Registered Nurse" means a person who maintains a current state licensure to practice as a Registered Nurse and as an Advanced Practitioner of Nursing; is a graduate of an accredited school of nursing and an American Nurses Association or National League of Nursing accredited program; works in a collaborative relationship with a Physician licensed in the state in which treatment is provided; and if prescribing medications, holds a current Certificate of Recognition from the State Board of Pharmacy in the state in which the treatment is provided. The Registered Nurse does not include the Employee or Dependents or any person who is a spouse, child, parent, brother, sister of the Employee or Dependent of the Participant and does not have the same legal address of the person receiving care.

69. "Residential Care Facility" means any licensed social rehabilitation facility, licensed group home, licensed family home, or similar licensed facility providing 24-hour nonmedical care to persons in need of personal services essential for sustaining the activities of daily living for the protection of the individual.

70. "Residential Treatment Program/Facility/Care" means a non-acute hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a residential treatment facility (licensure requirements for this residential level of care may vary by state) and contracted as a Network Provider.

71. "Retired Employee" or "Retiree" means a retired Employee of a Contributing Employer or of the Union, who meets the eligibility requirements of this Plan.

72. "Self-Payment" means payments made to the Plan by you if you do not work the minimum number of required hours of Covered Employment to maintain eligibility or if your cost is not otherwise covered by Contributions or other funding.

73. "Subrogation" means the Plan's right to withhold benefits and/or recover amounts paid on behalf of an Eligible Individual if another party or another's party insurer may be liable for the expenses.

74. "Surgical Center" or "Outpatient Surgical Facility" means a state licensed facility that meets all of the following requirements and is intended for outpatient surgical care:

a. It is primarily engaged in providing diagnostic and surgical facilities for ambulatory, outpatient surgical care;

b. It is equipped with permanent facilities for diagnosis and surgery and is staffed by Registered Nurses, Physicians and anesthetists licensed to practice medicine; and

c. It is a place other than a Doctor's office.

75. "Trust Agreement" means the Trust Agreement establishing the Teamsters Local 631 Security Fund and any modifications, amendments, extensions or renewals thereof.

76. "Trustees" or "Board of Trustees" means the persons designated in the Trust Agreement together with their successors designated and appointed in accordance with the terms of the Trust Agreement.

77. "Uniformed Services Employment and Reemployment Rights Act of 1994" ("USERRA") means the federal legislation governing the right to continued coverage and reestablishment of coverage when Active Employees are serving on active duty with the armed forces of the United States.

78. "Union" means the Teamsters, Chauffeurs, Warehousemen & Helpers Local Union No. 631 as specified in the Trust Agreement.

79. "Urgent Care" means Medically Necessary services which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is unreasonably delayed.

80. "Urgent Care Facility" means a facility that is equipped and operated mainly to render immediate treatment for an acute illness or injury.

81. "Utilization Review Organization" means an organization contracted with the Plan to review the appropriateness and quality of care and to deliver results-oriented cost containment through preadmission or procedure screening, second opinion referrals, Case Management and retrospective review programs.

82. "Workers' Compensation" means the laws of any state that impose liability on an employer of a person who is injured, becomes ill, or is killed as a result of, or in connection with, a work-related activity, or whose injury, illness, and/or death, arise out of, or in the course of such employment, or which impose such liability on the employer's Workers' Compensation insurance carrier.

For information regarding the Plan's Claims and Appeals Procedures, and your rights and deadlines to dispute a Claim denial, please refer to pages 109 to 118.

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