OPERATING ENGINEERS' LOCAL NO. 428 HEALTH AND WELFARE TRUST FUND

Summary Plan Description (SPD)
Plan Rules and Regulations
for
Active Employees, Early (non-Medicare eligible) Retirees,
and Medicare-eligible Retirees
describing the
Medical Plan (including prescription drugs and hearing care),
Indemnity Dental, Prepaid Dental, Vision Plan,
Life and AD&D Insurance and Weekly Disability Benefits

Amended, Restated and Effective: January 1, 2018

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TO ALL COVERED PARTICIPANTS

We are pleased to provide this booklet that is effective **January 1, 2018,** describing the medical, dental, vision, weekly disability, and life and accidental death and dismemberment benefits provided by the Operating Engineers' Local No. 428 Health and Welfare Trust Fund for you and your dependents. This booklet serves as the Summary Plan Description and the Plan Rules and Regulations for the Operating Engineers Local No. 428 Health and Welfare Trust Fund and replaces all other summary plan descriptions/plan rules and applicable amendments to those documents previously provided to Plan participants.

This booklet furnishes a description of the benefits to which you and your family are entitled, the rules governing these benefits, and the procedures that should be followed when making a claim.

- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.
- **The Fund's benefit program does not provide benefits for services that are not medically necessary or for which no basic need has been adequately documented.** The fact that a health care provider may recommend or advise you to enter a treatment program does not mean it is a covered expense.

Please familiarize yourself with the benefits described in this booklet in order to fully understand the extent of the benefits to which you are entitled.

- The Welfare Fund's benefits for employee **Life and Accidental Death and Dismemberment (AD&D)** are underwritten by a life insurance company whose name is listed on the Quick Reference Chart in the front of this document.
- The **Medical benefits** (including prescription drugs and hearing care) are self-funded and administered by an independent Claims Administrator whose name is listed on the Quick Reference Chart in the front of this document. The Fund has an agreement with a contracted Preferred Provider Organization (PPO) network for comprehensive benefits that consists of a large network of doctors, hospitals and other health care providers who provide health care services to you and your dependents at reduced costs.

  Within the medical plan benefits, we have contracted with a pharmacy benefit management company (referred to as the Prescription Drug Program) to provide discounted retail prescription drugs at participating pharmacies and discounted mail order prescriptions dispensed by their mail order facility. The name and address of the Prescription Drug Program is listed on the Quick Reference Chart in the front of this document.
- There are two **Dental benefits** offered under this Plan: a self-funded indemnity dental plan and a fully insured prepaid dental plan. Claims are administered for the self-funded indemnity dental plan by an independent Claims Administrator whose name and address is reflected on the Quick Reference Chart at the front of this document. Claims for the fully insured prepaid dental plan are administered by a dental insurance plan whose name and address is reflected on the Quick Reference Chart at the front of this document.
- The **Vision benefits** are self-funded and administered by an independent Vision Plan whose name and address is listed on the Quick Reference Chart in the front of this document.
- The **Weekly Disability benefits** are self-funded and administered by an independent Claims Administrator whose name is listed on the Quick Reference Chart in the front of this document.
- The **Life Insurance and Accidental Death and Dismemberment benefits** are insured.

Included in the back of the booklet is certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA). Any questions you may have should be directed to the Administrative Office where the staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

HOW TO FILE A HEALTH CLAIM

1. Choose a provider that participates in the PPO network, when possible.
2. Carry your ID card to identify you as a member of the PPO network.
3. Remember to contact the Medical Review Program for services that must be precertified (such as non-emergency Hospital Confinements) as outlined in Article II.
4. For information concerning eligibility, contact the Administrative Office or the Local Union.
5. Obtain a claim form from the Local Union or the Administrative Office. Complete the portion of the claim form pertaining to the covered participant in full; otherwise, it will be returned. The Plan must have an updated claim form on dependents every 6 months and on members every year.
6. The covered participant should be sure to keep separate records for each of their dependents and themselves.
7. On completion of the claim form, attach itemized bills and forward them to the Administrative Office. The sooner the completed claim form is received by the Administrative Office, the sooner it can be paid.
8. For claims assistance after a claim has been filed, contact the Administrative Office at their phone number and address listed on the Quick Reference Chart in the front of this document.

REMEMBER – It is your responsibility to notify the Administrative Office of any change in your address or the status of your dependents. The sooner the completed claim form is received by the Administrative Office, the sooner it can be paid!

IMPORTANT
The Plan must have an updated claim form on a member every year and on dependents every 6 months and on members every year.

HOW TO FILE A DISABILITY CLAIM

1. Obtain a disability claim form from the Administrative Office. The disability claims form needs to be completed by the participant and doctor.
2. Submit the completed disability claim form to the Administrative Office.
3. All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability.
4. To appeal a denial of a disability claim, see the Claims Filing and Appeal Information Article XVII of this document.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

To file a claim for life insurance or accidental death and dismemberment proceeds, a claim form should be obtained from the Administrative Office, completed and returned to the Administrative Office with a certified copy of the death certificate which carries the deceased's social security number. The benefits will be forwarded to the beneficiary in about seven days provided the claim form is completed correctly.

IMPORTANT

Please keep a record of the hours worked for participating employers along with check stubs. This information may be used to assist in establishing eligibility in the event of discrepancies.

REMEMBER – It is the eligible participant's responsibility to notify the Administrative Office of any changes in address or change in the status of dependents. See the Quick Reference Chart in this document for the address and phone number of the Administrative Office.

FOR HELP OR INFORMATION

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

QUICK REFERENCE CHART	
Information Needed	**Whom To Contact**
Claims Administrator (Administrative Office) • Claim forms (Medical Plan) • Medical Claims and Appeals • Weekly Short-Term Disability Claims and Appeals • Eligibility for Coverage • Plan Benefit Information • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC)	**Zenith American Solutions** 2001 W. Camelback Rd. Suite 350 Phoenix, AZ 85015-7404 Mailing Address: P. O. Box 16200 Phoenix, AZ 85011-6200 **Phone: 602-650-8161 or 800-669-1909** Fax: 602-248-8301 Website: https://edge.zenith-american.com
PPO Network • Medical Network Provider Directory (online only, at no cost) • Additions/Deletions of Providers Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield Plans outside of Arizona. The Fund has assumed all liability for claims payment based on the provisions and limitations stated in this plan document.	**Blue Cross and Blue Shield of Arizona (BCBSAZ)** P. O. Box 13466 Phoenix, AZ Website to find a network provider: www.azblue.com/chsnetwork (or contact the Administrative Office for assistance locating a network provider)
Medical Review Company • Precertification and appeals of review decisions: Prior authorization (precertification) is required for a variety of health care services including but not limited to all non-emergency (elective) hospital admissions, outpatient surgery in a hospital-based or free-standing surgery center, durable medical equipment in excess of $500, home health care, epidural injections, nerve conduction study, electromyogram test, rehabilitation therapy services, etc. See Article II for more information. • Second and Third Opinions • Concurrent Review and Case Management	**American Health Group (AHG)** Phone: (602) 265-3800 or (800) 847-7605 2152 S. Vineyard Mesa, AZ 85210

QUICK REFERENCE CHART	
Information Needed	**Whom To Contact**
Prescription Drug Program for Non-Medicare eligible Active Plan Participants and their eligible Dependents • Retail network pharmacies • Mail Order (Home Delivery) Pharmacy and Order forms • ID Cards, Prescription Drug Information, Formulary, Step Therapy and Drug quantity limit information • Preauthorization/precertification of Certain Drugs • Specialty Drug Management Program • Direct Member Reimbursement (claims submitted for non-network retail pharmacy use)	**CVS Caremark** Customer Service: 1-866-278-9682 Mail Order Address: Caremark P. O. Box 94467 Palatine IL 60094 www.caremark.com
Medicare Part D Prescription Drug Program for Medicare Eligible Retirees and their Medicare Eligible Dependents • Retail network pharmacies • ID Cards, Prescription Drug Information • Formulary, Step Therapy and Drug quantity limit information • Preauthorization/precertification of Certain Drugs	**SilverScript PDP** Customer Service (24/7): 1-866-235-5660. TTY users should call 711. P.O. Box 52424 Phoenix, AZ 85072-2424 SilverScript Employer PDP sponsored by Operating Engineers 428 is a Medicare Part D prescription drug plan. "Employer PDP" means that the plan is an employer-provided Medicare Part D prescription drug plan. The plan is offered by SilverScript Insurance Company, which is affiliated with CVS Caremark®.
Telemedicine Nationwide Network of Physicians • Free (no cost) web or phone-based consultation with a board-certified Physician (an electronic visit called an e-visit). • Physicians are available 24/7/365 for web or phone-based consultation, including diagnosis and treatment of medical issues. • The physician will review your medical history, diagnose the condition and can prescribe necessary medications. The physicians can diagnose non-emergency medical problems, like ear infection, colds, pink eye or sore throat, and recommend treatment. They can call in necessary medication to your preferred pharmacy. • The U.S.-based Physicians are board-certified in internal medicine, family practice, emergency medicine or pediatrics.	**Teladoc** Available 24/7/365 Phone: 1-800-Teladoc (835-2362) E-mail: membersupport@teladoc.com Website: www.teladoc.com Mobile App (App Store and Google Play): www.teladoc.com/mobile To use this electronic visit service you must register online at www.teladoc.com and can set up your account to be web, phone or mobile app.

QUICK REFERENCE CHART	
Information Needed	**Whom To Contact**
Weekly Short-Term Disability Insurance • Contact Zenith American Solutions for assistance with disability claims	**Zenith American Solutions** Phone: 602-650-8161 or 800-669-1909 2001 W. Camelback Road, Suite 350 Phoenix, AZ 85015-7404
Prepaid Dental Insurance • Prepaid Dental Provider Directory • Prepaid Dental Claims and Appeals	**Sun Life Assurance Company of Canada** (formerly called Assurant) One Sun Life Executive Park Wellesley Hill, MA 02481 Phone: (800) 733-7879 (main) (800)442-7742(dental claims) Website: www.sunlife.com/us
Indemnity Dental Plan • Indemnity Dental Provider Directory • Indemnity Dental Claims and Appeals	**Delta Dental Plan of Arizona** P. O. Box 4300 Phoenix, AZ. 85080-3000 Phone: 800-352-6132 www.deltadental.com
Vision Plan • Vision Provider Directory • Vision Claims and Appeals	**Vision Service Plan (VSP)** 3333 Quality Drive. Rancho Cordova, CA 95670 Member Services: 1-800-877-7195 www.vsp.com
Life and AD&D Insurance Coverage • Life and AD&D Claims and Appeals	**ULLICO** 1112 Ocean Drive Manhattan Beach, CA 90266 Phone: 1-800-431-5425 www.ullico.com
COBRA Administrator • Information About Eligibility and Coverage • Cost of COBRA Continuation Coverage • COBRA Premium payments	**Zenith American Solutions** 2001 W. Camelback Rd. Suite 350 Phoenix, AZ 85015-7404 Phone: 602-650-8161 Fax: 602-248-8301
Plan Administrator, HIPAA Privacy Officer and HIPAA Security Officer • Level 2 Claim Appeals • HIPAA Notice of Privacy Practice	**Board of Trustees of the Operating Engineers' Local No. 428 Health and Welfare Trust Fund** 2001 W. Camelback Rd. Suite 350 Phoenix, AZ 85015-7404 Phone: 602-650-8161 Fax: 602-248-8301

NOTICE TO PARTICIPANTS

The Board of Trustees reserves the right to amend, modify, or to discontinue all or part of this welfare Plan whenever, in its judgment, conditions so warrant. The benefits provided by this Plan are not in lieu of and do not affect any requirements for coverage by worker's compensation insurance laws or similar legislation.

Nothing in this booklet is meant to interpret, extend or change in any way the provisions expressed in the Plan or insurance policies. The Trustees shall have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and other related matters. The Trustees have full power to construe and interpret the provisions of the Agreement and Declaration of Trust for the Fund and the terms of the Plan. Any such determination and any such construction adopted by the Trustees in good faith shall be binding on all of the parties and beneficiaries of this Fund.

Only the Board of Trustees is authorized to interpret the plan of benefits described in this booklet. No employer, union representative, individual trustee, or any other person is authorized to interpret this Plan; nor can any such person act as an agent of the Board of Trustees.

Under the Plan and the Trust Agreement creating the Fund, the Board of Trustees or persons acting for them, such as a claims appeal committee, have sole authority to make final determinations regarding any application for benefits provided by the Plan/Fund and the interpretation of the Plan, the Trust Agreement, and any other regulations, procedures, or administrative rules adopted by the Board of Trustees. Decisions of the Board of Trustees, or, where appropriate, decisions of those acting for the Board of Trustees in such matters, are final and binding on all persons dealing with the Board of Trustees, the Fund, or the Plan, or claiming a benefit from the Plan. If a decision of the Board of Trustees or those acting for the Board of Trustees is challenged in court, it is the intention of the Board of Trustees, the parties to the Trust Agreement, and the Fund that such decision is to be upheld unless it is determined to be arbitrary or capricious; i.e., an abuse of the Trustees' discretion.

No participant, dependent, or any other person shall have any vested right to any benefit(s) provided by this Plan.

NOTE: As a courtesy to you, the Administrative Office may respond informally to oral questions. However, oral communications are not binding on the Fund and cannot be relied upon in any dispute concerning your benefits.

Verification of benefits is not a guarantee of payment.

Payment cannot be determined until the claim is received and reviewed.

IMPORTANT: The Administrative Office must have a completed **enrollment card** for you in their records. You must complete an enrollment card before claims can be processed. If you have not completed an enrollment card, obtain one from your Local Union Office or from the Administrative Office immediately, and send it to the Administrative Office. **All dependent social security numbers must be included**. You should send the Administrative Office a new enrollment card in the event that:

1. You change your home address;
2. You wish to change your beneficiary; or
3. There is any change in your family status by reason of marriage, birth, adoption or placement for adoption of a child, death, divorce, legal separation or annulment, loss of student status or loss of eligibility due to age for dependent children. It is your responsibility to notify the Fund of a divorce from your spouse or a child no longer qualifies as a dependent under this Plan. You may be required to repay any expenses paid on behalf of an ineligible dependent or divorced spouse.

REMEMBER: *The Administrative Office must have this enrollment card and proof of your dependent's status in order to process your claim.*

Additionally, the Plan must have an ***updated claim form*** *on dependents every 6 months and on members every year.*

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

- ✓ **Use Network (PPO) providers.** They charge less, and you pay less. And, Preventive Care is free when provided by Network PPO providers.
- ✓ **Choose Generic drugs when possible.** Ask your Doctor if a generic drug is appropriate for you. You'll pay less for generic drugs than for brand name drugs.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends for you. Make medication compliance your habit to a healthier life.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range) and to stay current on recommended immunizations and cancer screening tests.
- ✓ **Not feeling well?** Call your Network Doctor's office for help. Or, use the Telemedicine visit or go to a network Urgent Care facility instead of an emergency room (ER), if medically appropriate.
- ✓ **Precertify** your elective hospital admission, outpatient surgery, home health care, durable medical equipment over $500, certain outpatient prescription drugs and various other services, as explained in Article II, to help avoid a financial penalty.
- ✓ **Review Your Medical Bills.** If something on a medical bill just doesn't look right, contact the Administrative Office if you think there might be an error on a bill.

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

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All medical plan claims must be submitted to the Plan within 15 months from the date of service.

All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability.

No Plan benefits will be paid for any claim submitted after this period.

See also the Claim Filing and Appeal Information Article XVII for more information.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Administrative Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth and change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

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

Failure to give the Administrative Office a timely notice of the above noted events may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,

b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,

c. cause claims to not be considered for payment until eligibility issues have been resolved,

d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and/or vision benefits.

IMPORTANT

The Plan must have an updated claim form on a member every year and on dependents every 6 months and on members every year.

ARTICLE I: SCHEDULE OF BENEFITS

These Schedules of Benefits should be used in conjunction with the other Articles in this Plan that more completely describe the Medical, Dental, Vision, Disability, and Life Insurance benefits. See also the provision in the General Information Article.

IMPORTANT NOTE: Eligible individuals are covered for expenses incurred for most, but not all, medical services and supplies. The expenses the Plan covers are called eligible medical plan benefits and are described in the Schedule of Medical Benefits and in Article IX. **Read this booklet carefully to determine the conditions under which benefits are payable.** See Article VII for benefits for Medicare Retirees.

Section 1: Life and Accidental Death and Dismemberment (For Active Participants Only)	
Life Insurance (Death Benefit)	$12,000
Accidental Death and Dismemberment (AD&D)	$12,000
Accidental Death *(this is the combination of the death benefit and the AD&D benefit)*	$24,000

Section 2: Weekly Short-Term Disability Benefit (For Active Participants Only)	
Weekly Benefit Amount	$100
Maximum Benefit Duration	13 weeks
Benefits begin the first day for injury and the eighth consecutive day for illness. Refer to Article VIII "Weekly Short-Term Disability Benefit" for further details.	

Section 3: DEDUCTIBLES

The annual deductible is the amount you must pay each calendar year toward Allowed Charges, before the Plan begins to pay benefits. There are two types of annual deductibles: Individual and Family. The family deductible applies collectively to all covered persons in the same family. The annual deductible is explained on the Schedule of Medical Benefits.

Section 4: COINSURANCE PERCENTAGES

Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible, and any copayments required, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance.

The coinsurance related to a covered benefit is outlined below and described in more detail in the Schedule of Medical Benefits and in Article IX.

If you use the services of a Health Care Provider who is a member of the Plan's network (a Network Provider), you will be responsible for paying less money out of your pocket.

A 100% coinsurance percentage is paid by the Plan for the following Medical Plan services:

1. Second Surgical Opinion, up to $150 per consultation.
2. Hospice, limited to terminally ill persons accessed to have life expectancy of 6 months or less.
3. Accident (limited to the first $500 per accident).

4. Web or phone-based telemedicine consultation with a Physician when received through the Plan's contracted Telemedicine provider (see the Quick Reference Chart).
5. Wellness/Preventive Services mandated by Health Reform.

Coinsurance payable by the Plan is generally as outlined below with more details listed on the Schedule of Medical Benefits:

a. **A covered person resides in an area where there is a PPO network**:

- The Plan will pay 80% of covered expenses in excess of the deductible for charges made by Preferred PPO Providers; i.e., hospital physician, lab, etc., and other covered charges not available from a Preferred PPO Provider.
- Should a covered person **reside in the PPO network service area and use a Non-Preferred (Non-PPO) Provider**, reimbursement will be reduced to 50% of covered expenses after the covered person pays any applicable deductible. For use of a non-PPO emergency room for emergency services, the Plan pays emergency room services at the in-network level of benefits.

b. **A covered person resides in an area where there are NO PPO network providers**:

- The Plan will reimburse 80% of covered expenses which are in excess of the deductible for services obtained outside the Preferred PPO Provider area, and for services not available from a Preferred PPO Provider after the Participant pays any applicable copayment. Should a covered person travel to an area where there is a Preferred PPO Provider network, benefits will be payable in accordance with paragraph "a" above.

Section 5: COPAYMENT (COPAY)

A copayment (or copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan's copayments are indicated in the Schedule of Medical Benefits.

Copayments are to be paid in addition to your deductible. Copayments are not used to satisfy a deductible.

Section 6: OUT-OF-POCKET LIMIT

The Out-of-Pocket Limit is the most you pay for deductibles, copayment and coinsurance during the calendar year before your medical plan starts to pay 100% for covered essential health benefits received from Network providers.

The annual Out-of-Pocket Limit is explained in the Schedule of Medical Benefits. Note that the Medicare-eligible Retirees and their eligible Medicare-eligible Dependents have an annual Coinsurance maximum in addition to the annual Out-of-Pocket Limit, as explained on the Schedule of Medical Benefits.

Section 7: PRECERTIFICATION REQUIREMENTS OF THE PLAN

Precertification Review is a procedure, administered by the Medical Review Company, to assure that health care services are appropriate under accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary.

The address and phone number for the Medical Review Company is listed on the Quick Reference Chart at the front of this document.

The following services must be precertified (pre-approved) BEFORE the services are provided, or else a penalty will apply. Refer to Article II, for information on what happens if you fail to precertify.

SERVICES REQUIRING PRECERTIFICATION	
a)	**Non-emergency (elective) Hospital Admission, including transplants**. Note: precertification is required for delivery of a child **only when** the hospital stay lasts or is expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.
b)	**Admission to a Residential Treatment Program.**
c)	**Outpatient Surgery** performed in a hospital-based or free-standing surgery center.
d)	**Epidural injections**, such as a lumbar epidural steroid injection, performed in a physician office or outpatient surgery facility.
e)	**Durable Medical Equipment (DME) in excess of $500**.
f)	**Home health care.**
g)	**Rehabilitation therapy services including physical, occupational and speech therapy, plus cardiac and pulmonary rehabilitation services**. (**No retrospective authorization allowed.)**
h)	**Nerve conduction study (NCS),** a test to evaluate the function and electrical conduction of the motor and sensory nerves of the body to see how well and how fast the nerves can send electrical signals.
i)	**Electromyogram (EMG),** a test to measure the electrical activity of muscles at rest and during contraction.
j)	Administration of a cla**ss of drugs called "survival motor neuron-2 (SMN2)-directed antisense oliogonucleotides,"** which includes drugs such as Spinraza (nusinersen).
k)	**For individuals who plan to participate in a clinical trial**, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
l)	Any technique that uses genes to treat or prevent disease (**gene therapy**) including but not limited to Kymriah, Yescarta, Luxturna, etc.
m)	Note also that **certain prescription drugs** purchased through the retail pharmacy or mail order services also require precertification by contacting the Prescription Drug Program.
Prior notification does not mean benefits are payable in all cases.	
Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations. There is no requirement to precertify the use of a hospital-based emergency room visit.	

Emergency Hospitalization:

If an emergency requires hospitalization, there may be no time to contact the Medical Review Company before you are admitted. If this happens, the Medical Review Company must be notified of the hospital admission within 48 hours.

You, your Physician, the hospital, a family member or friend can make that phone call to the Medical Review Company. This will enable the Medical Review Company to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Physician or other Health Care Providers of the various In-Network support providers and benefits available for you and offer recommendations, options and alternatives for your continued medical care.

If you don't follow the Precertification Review requirements of the Plan there is a consequence. See Article II for information on the penalty for failure to precertify a service.

How Concurrent (Continued Stay) Review Works:

When you are receiving medical services in a hospital or other inpatient health care facility, the Medical Review Company will monitor your stay by contacting your Physician or other Health Care Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the plan.

How Case Management Works:

Case Management is a voluntary process, administered by the Medical Review Company. The Case Manager of the Medical Review Company will work directly with your Physician, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Non-Network Health Care Providers as needed.

You, your family, or your Physician may call the Case Manager of the Medical Review Company at any time at the telephone number shown on the Quick Reference Chart in the front of this document to ask questions, make suggestions, or offer information.

For more information on precertification, Concurrent Review and Case Management, see Article II.

Section 8: PREFERRED PROVIDER ORGANIZATION PROGRAMS (PPO NETWORK)

- **Network (also called Preferred Provider, Participating Provider, or Contracted Provider):** If an Active employee and their eligible dependents receives medical services or supplies from a Health Care Provider that is contracted with the Plan's medical network they will be responsible for paying less money out of their pocket. Health Care Providers who are under a contract with the network have agreed to accept the discounted amount the Plan pays for covered services, plus any additional copayments, deductibles or coinsurance you are responsible for paying, as payment in full, except with respect to claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance. In those cases, the contracts of Health Care Providers with the PPO do not require them to adhere to the discounted amount the Plan pays for covered services, and they may charge in excess of what this Plan considers an Allowed Charge.
- **Out-of-Network (also called Non-Network, Non-Preferred, Non-Participating, or Non-Contracted):** refers to providers who are not contracted with the medical plan's Network and who do not generally offer any fee discount to the participant or to the Plan. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due **in addition to** the Allowed charge payable by the Plan, also called balance billing.

  Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. **To avoid balance billing, use Network providers**.

Remember to use preferred providers to receive the maximum benefit from the Plan for lower out-of-pocket costs. The Preferred Provider Organization (PPO) consists of a network of Physicians, Hospitals and other Health Care Providers who have agreed to provide health care service for a discounted price.

You may access the Internet to find a doctor in your area by using the PPO Network's website listed on the Quick Reference Chart at the front of this document. Refer to the PPO Network Article II for further details.

Section 9: SPECIAL REIMBURSEMENT PROVISIONS

The following chart explains the Plan's special reimbursement for services when certain Out-of-Network providers are used. The Plan Administrator or its designee determines if and when the following special reimbursement circumstances apply to a claim after the normal claim adjudication processes have been followed/investigated. Medical records may be requested in order to assist with a determination on the need for a special reimbursement provision.

Allowed charge is defined in the Definitions Article of this document.

SPECIAL REIMBURSEMENT PROVISIONS This chart explains the Plan's special reimbursement provisions if the services of certain Out-of-Network Providers are used. The Plan Administrator or its designee determines if/when the following reimbursement applies to a claim.	**WHAT THE PLAN PAYS (toward eligible claims submitted by an Out-of-Network provider)**
a. The individual was treated/confined in a network facility but an Out-of-Network provider (outside the patient's control) performed certain Medically Necessary covered services such as professional fees for radiology, anesthesia, assistant surgeon, pathology, laboratory, and emergency room services. b. The medical plan does not have a network provider qualified or available to provide the preventive services required by Health Reform so the participant must use the services of a non-network provider and claims will be reimbursed without any participant cost-sharing, in the same manner as if a network provider had been used. c. Child resides temporarily outside the service area while attending college. d. Child resides outside the service area under a QMCSO. e. The individual had care for a medical emergency (as emergency is defined in this Plan) at a provider outside the Network service area. f. Ancillary services (including but not limited to professional fees related to radiology, anesthesia, pathology, lab, emergency room physician, assistant surgeon) received from an Out-of-Network provider in connection with a visit to or service performed by a network provider, if the choice of the Out-of-Network provider who performed the ancillary service was outside the patient's control. For example, the Network provider accidentally sends the patient's lab work to an Out-of-Network lab for processing or an Out-of-Network anesthesiologist provides anesthesia during surgery performed by a network physician. g. If the individual resides more than 50 miles outside the Network service area. (Service area is defined as the State of Arizona.) h. Within the network service area there is no Network provider qualified by area of professional specialty or practice, or available to provide Medically Necessary eligible health care services.	As if the care was provided In-Network including deductible, coinsurance, copays and Out-of-Pocket Limit and the allowance for the non-network provider's eligible bills will be reimbursed according to the Allowed Charge. See the definition of Allowed Charge in the Definitions Article of this Plan.
i. Use of an Out-of-Network provider when a network provider was available to be used.	As if the care was provided Out-of-Network including deductible, coinsurance, copays and Out-of-Pocket Limit and the allowance for bills will be reimbursed according to the Allowed Charge for Out-of-Network providers.

Section 10: SCHEDULE OF MEDICAL BENEFITS

- This schedule is not a complete list of covered expenses. See also Article IX for more information, plus the Definitions and Exclusions Articles of this document.
- The deductible applies to all benefits except where noted. Certain services require precertification to avoid non-payment or a financial penalty, as noted in Article II.
- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)
Deductible (per calendar year) for the Medical Plan • The annual deductible is the amount you must pay each calendar year toward Allowed Charges, before the Medical Plan begins to pay benefits. There are two types of annual deductibles: Individual and Family. The family deductible applies collectively to all covered persons in the same family. • Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles, meaning that non-covered expenses or expenses in excess of Allowed Charges cannot be used to satisfy the deductible. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. The amount applied to a Deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan. • Copayments and penalties for failure to obtain precertification (preauthorization) for services do not accumulate to meet a Deductible. • The deductible does not apply to second surgical opinion, the hearing care benefit, In-network Preventive Care benefits, the separate accident benefit, Outpatient Prescription Drugs (Retail or Mail Order) and Web or phone-based telemedicine consultation with a Physician through the Plan's contracted telemedicine provider. • Note that Medical plan deductibles are NOT interchangeable, meaning you may not use any portion of a network deductible to meet an Out-of-Network deductible and vice versa. • Deductible Carryover: Covered expenses which are incurred in the last three months of a calendar year and which are applied toward a covered person's deductible for that year shall be so applied for the next calendar year also. • Common Accident Provision: During any calendar year, not more than one deductible amount will be deducted for covered expenses incurred by all the covered persons in a family due to injuries in a common accident. The term "common accident" means an accident that involves two or more covered persons of the same family.	$800/individual $2,000/family	$2,500/individual $5,000/family	$100 per person per calendar year. The deductible does not apply to outpatient drug benefits under the Medicare Part D PDP.

Section 10: SCHEDULE OF MEDICAL BENEFITS

- This schedule is not a complete list of covered expenses. See also Article IX for more information, plus the Definitions and Exclusions Articles of this document.
- The deductible applies to all benefits except where noted. Certain services require precertification to avoid non-payment or a financial penalty, as noted in Article II.
- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)
Out-of-Pocket Limit (per calendar year) • The Out-of-Pocket Limit is the most you pay for deductibles, copayment and coinsurance during a one-year period (the calendar year) before your medical plan starts to pay 100% for covered essential health benefits received from Network providers. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • There is no Out-of-Pocket Limit on the use of Out-of-Network providers, except that emergency services performed in an Out-of-Network Emergency Room will accumulate to meet the Network Out-of-Pocket Limit. • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person" annual out-of-pocket limit. • There is a separate outpatient prescription drug out-of-pocket limit per calendar year. The combination of the Out-of-Pocket Limits for medical plan and outpatient prescription drugs will not exceed the limits set by Health Reform regulations. • The Out-of-Pocket Limit does not include or accumulate: 1) Premiums and/or contributions for coverage, 2) Expenses for medical services or supplies not covered by the Plan, 3) Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for out-of-network providers, 4) Penalties for non-compliance with the Plan's Medical Review Program requirements, 5) Expenses for the use of out-of-network providers, except that covered emergency services performed in an Out-of-Network Emergency Room do accumulate to the In-network Out-of-Pocket Limit, 6) Charges in excess of the Medical Plan's maximum benefits, 7) Dental Plan and Vision Plan expenses. 8) The Medical Plan out-of-pocket limit does not include outpatient drug expenses. The Outpatient drug out-of-pocket limit does not include medical plan expenses. • Medicare-eligible Retirees and their Medicare-eligible Dependents have an **annual coinsurance maximum** which once reached, the Medical Plan pays 100% of coinsurance for covered medical (not drug) benefits. For Medicare-eligible Retirees and their Medicare-eligible Dependents, with **outpatient drug coverage under the SilverScript PDP**: you will qualify for catastrophic drug coverage once you reach an out-of-pocket cost of $5,000/year	**For Medical Plan benefits:** $4,000/individual $8,000/family **For outpatient prescription drugs:** $3,350/individual $6,700/family	There is no Out-of-Pocket Limit on the use of Out-of-Network providers. Amounts that you pay for use of an Out-of-Network provider do not count toward reducing the maximum amount a participant is required to pay to use a PPO Network Provider. However, emergency services performed in an Out-of-Network Emergency Room will accumulate to meet the Network Out-of-Pocket Limit	**Medical Plan Coinsurance Maximum:** You pay a maximum of $2,000 of coinsurance per person per calendar year. **Medical Plan Out-of-Pocket Limit:** The most you pay for deductibles, copayment and coinsurance during a calendar year (before the medical plan starts to pay 100% for covered benefits): **$2,100/individual and $14,700/family**. See outpatient drug coverage under SilverScript, to the left.

Section 10: SCHEDULE OF MEDICAL BENEFITS

- This schedule is not a complete list of covered expenses. See also Article IX for more information, plus the Definitions and Exclusions Articles of this document.
- The deductible applies to all benefits except where noted. Certain services require precertification to avoid non-payment or a financial penalty, as noted in Article II.
- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)
Ambulance • Covered expenses for licensed Ambulance service is limited to expense incurred to transport a covered person to the nearest facility qualified to treat the illness/injury of such person. However, no other expenses in connection with travel are included. a. **Ground vehicle transportation** to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency, acute illness or for inter-health care facility transfer. b. **Air transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status. When air/sea ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's emergency condition. See the Definition of Allowed Charge at is relates to payment for air ambulance services.	Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met
Ambulatory Surgery	See Outpatient Surgery in this Schedule		
Diabetes Education Course/Program • Coverage is payable for a formal Diabetes Education course/program taught by a Certified Diabetes Educator and recognized as an acceptable program by the American Diabetes Association. • A diabetes education program is payable when a covered person is initially diagnosed with diabetes. A refresher course is payable once each year for up to 5 times.	No charge. Deductible does not apply.	Not covered.	Plan pays 80% after deductible met
Drugs (Outpatient prescription drugs)	See Section 11 in this Article.		
Durable Medical Equipment (DME) • Includes coverage for diabetic glucose meter, breast pump when breastfeeding, and oxygen. • **Durable Medical Equipment in excess of $500 must be precertified** through the Medical Review Company, see Article II.	Breast pump: No charge. Deductible does not apply. All other DME: Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met

Section 10: SCHEDULE OF MEDICAL BENEFITS

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- The deductible applies to all benefits except where noted. Certain services require precertification to avoid non-payment or a financial penalty, as noted in Article II.
- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)
Electronic Visit (web or phone telemedicine consultation) Consultation using video or teleconferencing to communicate with a Physician 24/7/365 for diagnosis and treatment of medical issues. No charge for this service. Refer to the Quick Reference Chart for contact information for the telemedicine provider.	Plan pays 100%. Deductible does not apply.	Not covered.	Plan pays 80% after deductible met
Emergency Room (ER) Visit: • $250 copay per visit for a PPO or Non-PPO emergency room facility. • The copay is waived if the ER visit is followed by a subsequent immediate inpatient hospital admission, results from outpatient surgery, or is due to treatment of an accidental injury received within 48 hours of the accident. • The Plan pays 100% coinsurance, no deductible applies, for the first $500 per accident per person. See Article X for more information on the Separate Accident benefit.	Plan pays 80% after you pay your deductible and a $250 copay per visit.	Plan pays 80% after you pay your deductible and a $250 copay per visit.	Plan pays 80% after deductible met
Hearing care expenses • External hearing aid limited to $350 per ear payable once in a 3-year period. The external hearing aid dollar limit does not apply to implantable hearing devices that function as a prosthetic device, such as a cochlear implant. • A hearing exam (audiology exam) is not subject to the $350/ear benefit.	Plan pays 80%. Deductible does not apply.	Plan pays 50%. Deductible does not apply.	Plan pays 80% after deductible met
Home Health Care and Home Infusion Therapy Services • Payable to a maximum of 120 visits per calendar year. • Four (4) hours of home health aide service is considered as one (1) home health care visit. • Home health care must be precertified through the Medical Review Company, see Article II.	Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met
Hospice services • Payable for terminally ill persons with a life expectancy of 6 months or less. • Coverage includes inpatient hospice facility or home care hospice program.	Plan pays 100% after deductible met	Plan pays 100% after deductible met	Plan pays 80% after deductible met

Section 10: SCHEDULE OF MEDICAL BENEFITS

- This schedule is not a complete list of covered expenses. See also Article IX for more information, plus the Definitions and Exclusions Articles of this document.
- The deductible applies to all benefits except where noted. Certain services require precertification to avoid non-payment or a financial penalty, as noted in Article II.
- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)
Hospital Services (Inpatient) • Room and board – not to exceed semiprivate room rate, Limit does not apply to a specialty care unit (e.g. ICU, CCU). • Inpatient medical and surgical services and inpatient prescription drugs. • **Must precertify an elective hospital admission** through the Medical Review Company, see Article II. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with medically necessary dental services covered by the Dental Plan if the claims administrator determines that hospitalization or outpatient surgery facility care is medically necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this medical plan.	Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met
Laboratory (Outpatient) • Certain preventive tests are covered at no charge from in-network providers, as explained under the Wellness/Preventive benefits. No coverage for preventive services from non-PPO providers. • **Must precertify certain tests** through the Medical Review Company, see Article II.	Plan pays 80% after deductible met.	Plan pays 50% after deductible met.	Plan pays 80% after deductible met

Section 10: SCHEDULE OF MEDICAL BENEFITS

- This schedule is not a complete list of covered expenses. See also Article IX for more information, plus the Definitions and Exclusions Articles of this document.
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- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)
Maternity services • Ultrasounds and delivery expenses payable for a female employee, retiree, or spouse only. • No coverage is provided for maternity or delivery expenses of Dependent children, except for female preventive services and complications of pregnancy as explained in Article IX. • Under this Plan, routine prenatal obstetrical office visits and other ACA-mandated preventive services are considered to be female preventive services. Preventive services are no charge when provided by in-network providers; no coverage from non-PPO providers. • Precertification is required for delivery of a child only when the hospital stay lasts or is expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section (see Article II).	Female ACA-required preventive services (including maternity office visits) and breastfeeding counseling: Plan pays 100%. Deductible does not apply. All other services: Plan pays 80% after deductible met.	Plan pays 50% after deductible met.	Plan pays 80% after deductible met
Mental and Nervous and Substance Abuse Expenses: • **Outpatient treatment** for mental/nervous or substance abuse, including outpatient visits and other outpatient services including partial hospitalization (partial day care) and intensive outpatient programs (IOP). • **Inpatient treatment:** Inpatient hospital admission and residential treatment program admission. • **Must precertify an elective hospital admission or residential treatment program admission** through the Medical Review Company, see Article II. • Refer to the section titled "Mental/Nervous and Substance Abuse" under the "Comprehensive Medical Expense Benefits" Article IX for additional information regarding mental/nervous and substance abuse benefits.	Outpatient Visits, Other Outpatient Services, Inpatient Admission and Residential Treatment Program: Plan pays 80% after deductible met.	Outpatient visits and other outpatient services: Plan pays 50% after deductible met Inpatient Admission and Residential Treatment Program: Plan pays 50% after deductible met	Plan pays 80% after deductible met
Musculoskeletal adjustment (e.g. spinal manipulation) services • Payable up to a maximum of 15 visits per person per calendar year, plus a maximum of 1 office visit per 6 months.	Plan pays 80% after deductible met.	Plan pays 50% after deductible met	Plan pays 80% after deductible met

Section 10: SCHEDULE OF MEDICAL BENEFITS

- This schedule is not a complete list of covered expenses. See also Article IX for more information, plus the Definitions and Exclusions Articles of this document.
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- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)
Nutritional Counseling • For services of a Registered Dietitian or licensed or certified Nutritionist, the benefit maximum is 5 visits per person per calendar year. • Benefits are payable at no charge from in-network providers only. • This visit limit does not apply to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health or substance abuse condition, such as an eating disorder. • Certain other counseling is payable as a preventive benefit. See also the Wellness/Preventive benefits in Article IX.	Plan pays 80% after deductible met. ACA mandated intensive behavioral counseling: No charge. Deductible does not apply.	Not covered.	Plan pays 80% after deductible met
Outpatient Surgery in a hospital-based or free-standing ambulatory surgical facility • **Outpatient surgery requires precertification** through the Medical Review Company, see Article II.	Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met

Physician and other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility, outpatient/ambulatory surgery center or other covered health care facility location.
• Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon
  • Assistant surgeon (if Medically Necessary): payable up to 20% of the allowable charge for the primary surgeon
  • Anesthesia provided by Physicians and Certified Registered Nurse Anesthetists
  • Pathologist, Radiologist, Podiatrist (DPM)
  • Physician Assistant; Nurse Practitioner; Certified Nurse Midwife
• See also the telemedicine electronic visit available as described on the Quick Reference Chart.
• **Certain services require precertification**, like epidural injection, injection of Spinraza, gene therapy, etc. Contact the Medical Review Company, see Article II.
	Telemedicine electronic visit: No charge. Deductible does not apply. (See the Quick Reference Chart)
	
	All other professional fees: Plan pays 80% after deductible met
		Plan pays 50% after deductible met
		
		Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
			Plan pays 80% after deductible met

Prescription Drugs (Outpatient prescription drugs)	See Section 11 in this Article.		

Section 10: SCHEDULE OF MEDICAL BENEFITS

- This schedule is not a complete list of covered expenses. See also Article IX for more information, plus the Definitions and Exclusions Articles of this document.
- The deductible applies to all benefits except where noted. Certain services require precertification to avoid non-payment or a financial penalty, as noted in Article II.
- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)
Preventive Service	See Wellness in this Schedule.		
Radiology Services (Outpatient) • Plan covers technical and professional fees associated with diagnostic and curative radiology services, including imaging studies like CT, MRI, PET scan, and radiation therapy. • Certain preventive tests are covered at no charge from in-network providers as explained under the Wellness/Preventive benefits. No coverage for preventive services from non-PPO providers. • Must precertify certain tests, like electromyogram and nerve conduction study, through the Medical Review Company, see Article II.	Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met
Rehabilitation Services: Outpatient Physical, Occupational and Speech therapy, Cardiac and Pulmonary Rehabilitation services • Must precertify rehabilitation services through the Medical Review Company, see Article II. No retrospective authorization allowed.	Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met
Second surgical opinion • Charges for a Second opinion consultation made by a board-certified specialist for an opinion as to the need for proposed elective surgery. Limited to $150 per consultation.	Plan pays 100%, up to the $150 maximum. Deductible does not apply.	Plan pays 100% up to the $150 maximum. Deductible does not apply.	Plan pays 100%, up to the $150 maximum. Deductible does not apply.
Separate accident expense benefit (See also Article X for more information) • Limited to $500/accident. No deductible applies.	Plan pays 100%, up to the maximum. Deductible does not apply.	Plan pays 100%, up to the maximum. Deductible does not apply.	Plan pays 100%, up to the maximum. Deductible does not apply.
Skilled Nursing Facility (SNF) • Payable to a maximum of 60 days per disability.	Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met
Urgent Care Facility	Plan pays 80% after deductible met	Plan pays 50% after deductible met	Plan pays 80% after deductible met

Section 10: SCHEDULE OF MEDICAL BENEFITS

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- The deductible applies to all benefits except where noted. Certain services require precertification to avoid non-payment or a financial penalty, as noted in Article II.
- Covered expenses for certain non-network providers may be subject to the Special Reimbursement Provisions outlined in this document.
- Covered expenses for members who reside outside the state of Arizona are paid at the in-network PPO level of benefits.

BENEFIT DESCRIPTION	Plan Pays		
	Active Plan Participants, Early Retirees, and their eligible Dependents PPO Network (In-network)	Active Plan Participants, Early Retirees, and their eligible Dependents Non-PPO (Non-network)	Medicare Eligible Retirees and their Medicare-eligible Dependents (Network not Required)

Wellness/Preventive Services
 	
The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable preventive services, including immunizations:
• https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at
  • http://www.cdc.gov/vaccines/schedules/hcp/index.html,
  • http://www.hrsa.gov/womensguidelines/ and
  • http://www.uspreventiveservicestaskforce.org/BrowseRec/Index (A and B rated recommendations).
 	
The Plan covers **immunizations** recommended by both Health Reform regulations and in accordance with the Centers for Disease Control & Prevention (CDC). There is no cost-sharing when immunizations are obtained from a network retail pharmacy or during a network physician office visit.
See Article IX for more details on covered preventive services.
	Plan pays 100%. Deductible does not apply.	Not covered.	Plan pays 100%. Deductible does not apply.

All other covered expenses (noted in Article IX) but not outlined in this Schedule of Benefits.	Plan pays 80%, after deductible met.	Plan pays 50%, after deductible met.	Plan pays 80% after deductible met.
Covered expenses (not outlined in this Schedule of Benefits) which are not available from a preferred PPO provider.	See the Special Reimbursement Provisions explained earlier in this Article I.	See the Special Reimbursement Provisions explained earlier in this Article I.	Plan pays 80% after deductible met.

Section 11: SCHEDULE OF OUTPATIENT RETAIL AND MAIL ORDER PRESCRIPTION DRUG BENEFITS FOR NON-MEDICARE ELIGIBLE PLAN PARTICIPANTS

The Trustees have contracted with a pharmacy benefit management company (referred to as the Prescription Drug Program) to provide discounted outpatient retail and mail order prescription drugs.

Some prescriptions are subject to precertification (to avoid non-payment), quantity limits or step therapy requirements. Contact the Prescription Drug Program (listed on the Quick Reference Chart) for more information.

Mail Order should be used for maintenance medications after the first fill at a Retail pharmacy.

Medicare-eligible Retirees and their Medicare-eligible Dependents are not eligible for the outpatient drug benefits described in this section, because these individuals are automatically enrolled in an insured Medicare Part D Prescription Drug Program (PDP).

The outpatient drug benefits under the insured Medicare Part D prescription drug program (PDP) are outlined in Article VII.

More information about outpatient drug benefits under the Medicare Part D prescription drug program is available in the Evidence of Coverage booklet provided by the PDP and by contacting the Medicare Part D prescription drug program listed on the Quick Reference Chart in the front of this document.

Out-of-Pocket Limit on Outpatient Drugs for Non-Medicare plan participants:

The Out-of-Pocket Limit on Outpatient Drugs is the most you pay for deductibles, copayment and coinsurance during a one-year period (the calendar year) before your medical plan starts to pay 100% for covered outpatient drugs.

- Covered expenses are applied to the Out-of-Pocket Limit on Outpatient Drugs in the order in which eligible claims are processed by the Prescription Drug Program.
- The Out-of-Pocket Limit on Outpatient Drugs per calendar year is $3,350/individual $6,700/family.
- The family Out-of-Pocket Limit on Outpatient Drugs accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person" annual Out-of-Pocket Limit on Outpatient Drugs.
- There is a separate medical plan out-of-pocket limit per calendar year. The combination of the Out-of-Pocket Limits for medical plan and outpatient drugs will not exceed the limits set by Health Reform regulations.
- The Out-of-Pocket Limit does not include or accumulate**:**
    1) Premiums and/or contributions for coverage,
    2) Expenses for outpatient drugs that are not covered by the Plan,
    3) Charges in excess of the Allowed Charge determined by the Plan,
    4) Charges in excess of a maximum drug benefit, and
    5) Medical Plan, Dental Plan and Vision Plan expenses.

Below is a summary of the benefits provided under the **outpatient prescription drug program for Non-Medicare plan participants**:

RETAIL PRESCRIPTION DRUGS		
Benefit	Network Retail Pharmacy Location	Non-Network Location
Maximum Supply per Retail Prescription Refill	Up to 30-day supply	
Generic Drug	You pay 20% to a maximum of $5.00. Certain over the counter and prescription drugs (such as FDA-approved generic contraceptives, tobacco cessation products, etc.) are payable in accordance with Health Reform when you have a prescription and use an in-network pharmacy. See also page 46 for more information on drug coverage under Health Reform.	The Prescription Drug Program reimburses up to 70% of Allowed Charges for a non-network pharmacy and up to 80% of Allowed Charges for a non-network pharmacy when traveling or residing out of the network pharmacy area.
Formulary Brand Name Drug	You pay 20% to a maximum of $30.00	
Non-formulary Brand Name Drug	You pay 20% to a maximum of $50.00	
Specialty Drugs (up to a 30-day supply)	You pay a $100 copay	No coverage

MAIL ORDER PRESCRIPTION DRUGS Plan will pay 100% after the copay for mail order prescriptions filled by the contracted mail order service.	
Maximum Supply per Mail Order (Home Delivery) Prescription Refill	Up to a 90-day supply
Generic Drug	$10 copay per prescription
Formulary Brand Name Drug	$50 copay per prescription
Non-formulary Brand Name Drug	$75 copay per prescription

If you use a network (PPO) pharmacy, simply present your Operating Engineers' Local No. 428 Health and Welfare Trust Fund ID card to the participating pharmacist along with the prescription to receive up to a 30-day supply.

Certain prescription drugs need precertification by contacting the Prescription Drug Program, see Article II.

If you have questions about the location of the nearest participating pharmacy or questions regarding the prescription drug program, you may contact the prescription drug program at the address and phone number listed on the Quick Reference Chart on the front of this document.

Note: The Trustees may enter into Preferred Provider arrangements for pharmaceutical drugs with enhanced reimbursement. Please review the materials relative to this Plan or contact the Fund office. For additional details regarding the Retail and Mail Order Prescription Program refer to the Comprehensive Medical Benefits Article IX.

Section 12: SUMMARY OF DENTAL PLAN BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

See also the Dental Plan Benefit Article XIV and applicable dental exclusions for additional information on dental benefits.

SUMMARY OF DENTAL PLAN BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS *See also the Dental Plan Benefit Article XIV and applicable dental exclusions for additional information on dental benefits.*		
Dental Plan Options	Indemnity Dental Plan	Prepaid Dental Plan[1]
Calendar Year Deductible	$50/person and $150/family	None
Preventive Dental Services	80% of the Allowed Charge, not subject to the deductible	100% after copay
Basic Dental Services	80% of the Allowed Charge, after deductible met	100% after copay
Major Dental Services	60% of the Allowed Charge, after deductible met	100% after copay
Maximum Dental Benefit Per Person Per Calendar Year	$2,000 per year for individuals age 18 and older. No maximum for children under age 18 years.	None

[1]: Copays for the prepaid dental plan are available by contacting the prepaid plan at their number listed on the Quick Reference Chart in the front of this document.

Section 13: VISION PLAN BENEFITS

The Schedule of Vision Benefits is displayed below. Vision benefits are available for Active employees and Early Retirees. For more information on Vision plan benefits refer to Article XV.

SCHEDULE OF VISION BENEFITS This chart shows what the Vision Plan pays. See also the Vision Plan Exclusions in Article XV.			
Covered Vision Benefits	Explanations and Limitations	Vision Plan Pays	
		In Network Provider	Non-Network Provider
Vision Examination • Includes analysis of visual function, including prescription of glasses, where indicated.	• One vision exam payable every 12 months.	Covered in full.	Up to $36.
Frames for Eyeglasses	• One frame payable every 24 months.	Value Frames: 100% after a $20 copay for lenses & frames	Up to $31.

SCHEDULE OF VISION BENEFITS This chart shows what the Vision Plan pays. See also the Vision Plan Exclusions in Article XV.			
Covered Vision Benefits	Explanations and Limitations	Vision Plan Pays	
		In Network Provider	Non-Network Provider
Lenses for Eyeglasses	• Lenses payable once each 12 months, if the prescription change indicates. • Standard lenses are covered meaning, CR-39 basic plastic or white (clear) glass lenses. • A single vision, bifocal, trifocal lens is covered once each Plan year.	Single Vision (Standard): 100% Lined Bifocals: 100% Lined Trifocals: 100%	Single Vision: up to $25. Lined Bifocals: up to $41. Lined Trifocals: up to $53. Lenticular: up to $100 If only one lens is needed, the allowance will be one-half the pair allowance.
Contact Lenses Medically necessary contact lenses are to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative as determined by the Vision Plan.	• The participant is to pay the difference between the cost of contact lenses and the amount allowed under this Vision Plan. • You may use your annual contact lens allowance toward permanent and/or disposable lenses.	Cosmetic Lenses (not medically necessary): up to $90 allowance Contact Lenses (medically necessary): up to $300 with prior authorization	Cosmetic Lenses (not medically necessary): Covered up to $60 allowance Contact Lenses (medically necessary): Covered up to $60 allowance

ARTICLE II: PPO NETWORK, MEDICAL REVIEW & PRECERTIFICATION

Section 1: Overview

The Fund has an agreement with a preferred provider organization, (PPO) whose name and address is reflected on the Quick Reference Chart at the front of this document. A preferred provider organization is a large network of doctors, hospitals and other health care providers who provide health care services to non-Medicare-eligible Active Employees and their Dependents.

The preferred provider network includes doctors, hospitals, surgical facilities, medical laboratories and ancillary services designed to provide quality medical care at reduced costs. Your out-of-pocket costs will be lowered by selecting services from the Preferred Provider Organization (PPO) network. The doctors, hospitals and health care providers are outlined in the Participating Provider Directory, at no cost, or by the Internet website reflected on the Quick Reference Chart at the front of this document.

Covered expenses for care provided through the network are based on the negotiated charge or specific rate of reimbursement agreed upon between the provider and the Preferred Provider Organization (PPO) network. You or your dependents will not be responsible for any expenses in excess of this negotiated charge.

Section 2: Important Guidelines to Remember:

1. Choose Preferred (PPO) Providers.

2. Carry the ID card to identify you as a participant in the Preferred Provider Organization (PPO).

3. Remember to call the Medical Review Company reflected on the Quick Reference Chart at the front of this document.

Guideline #1 - Choose Preferred PPO Providers

Your out-of-pocket costs will be lowered by choosing to receive health care from Preferred Providers. Use the Preferred Provider Organization Directory or the Internet website of Participating Providers for help in selecting the doctor for a specific area.

The plan also offers web or phone-based electronic Physician consultation services (an electronic visit). Refer to the Quick Reference Chart for more information on telemedicine.

Note: If the covered person is advised to have surgery or is referred to a specialist, be sure to advise the doctor in advance that health care services should be received from Preferred Provider Organization (PPO) doctors, assistant surgeons, anesthesiologists, hospitals, laboratories, home health agencies, etc. This is the covered person's responsibility and will reduce costs.

Guideline #2 - The Participant Should Carry Their ID Card To Identify Themselves as a PPO Network Member

In order to receive Preferred Provider Organization (PPO) in network healthcare benefits, inform the doctor's office or hospital that the eligible participant or dependents have access to the PPO network. The best way to do this is to carry the PPO ID card. While the card does not guarantee coverage, it does serve to identify the covered person as PPO network participant.

Note: If the card is misplaced, participants are identified in the system by their Social Security number and/or unique identification number. This will help the doctor when referring the covered person to other doctors and in selecting hospitals, surgical facilities, laboratories, home health agencies, etc.

Guideline #3 - Remember to Contact the Medical Review Company in order to properly precertify certain health care services.

Section 3: Medical Review (Precertification, Concurrent Review and Case Management)

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

To enable your plan to provide coverage in a cost-effective way, your plan has adopted a Medical Review Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the plan and all its benefits. If you follow the procedures of the plan's Medical Review Program, you may avoid some Out-of-Pocket costs. However, if you do not follow these procedures, your plan provides reduced benefits, and you will be responsible for paying more out of your own pocket.

The Plan's Medical Review Program is administered by an independent professional company operating under a contract with the Plan (hereafter referred to as the Medical Review Company).

Precertification Requirements of the Plan:

Precertification Review is a procedure, administered by the Medical Review Company, to assure that health care services are appropriate under accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary.

For non-Medicare-eligible Active Employees and their Dependents, the following services must be precertified (pre-approved) BEFORE the services are provided, or else a penalty will apply:

SERVICES REQUIRING PRECERTIFICATION	
a)	**Non-emergency (elective) Hospital Admission, including transplants**. Note: precertification is required for delivery of a child **only when** the hospital stay lasts or is expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.
b)	**Admission to a Residential Treatment Program.**
c)	**Outpatient Surgery** performed in a hospital-based or free-standing surgery center.
d)	**Epidural injections**, such as a lumbar epidural steroid injection, performed in a physician office or outpatient surgery facility.
e)	**Durable Medical Equipment (DME) in excess of $500**.
f)	**Home health care.**
g)	**Rehabilitation therapy services including physical, occupational and speech therapy, plus cardiac and pulmonary rehabilitation services**. (**No retrospective authorization allowed.)**
h)	**Nerve conduction study (NCS),** a test to evaluate the function and electrical conduction of the motor and sensory nerves of the body to see how well and how fast the nerves can send electrical signals.
i)	**Electromyogram (EMG),** a test to measure the electrical activity of muscles at rest and during contraction.
j)	Administration of a cla**ss of drugs called "survival motor neuron-2 (SMN2)-directed antisense oliogonucleotides,"** which includes drugs such as Spinraza (nusinersen).
k)	**For individuals who plan to participate in a clinical trial**, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
l)	Any technique that uses genes to treat or prevent disease (**gene therapy**) including but not limited to Kymriah, Yescarta, Luxturna, etc.
m)	Note also that **certain prescription drugs** purchased through the retail pharmacy or mail order services also require precertification by contacting the Prescription Drug Program.
Prior notification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations. There is no requirement to precertify the use of a hospital-based emergency room visit.	

How Precertification Works:

If you are planning to have any of the above noted health care services, you or your Physician must call the Medical Review Company at the telephone number shown in the Quick Reference Chart in the front of this document.

1. **Calls for elective services should be made at least 7 days before the expected date of service.**
2. The caller should be prepared to provide all of the following information: the Fund's name, employee's name, patient's name, address, and phone number and social security number (or unique identification number); Physician's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. When calling to precertify, if the preservice review process was not properly followed the caller will be notified as soon as possible but not later than 5 calendar days after your request.
4. If additional information is needed, the Medical Review Company will advise the caller. The Medical Review Company will review the information provided, and will let you, your Physician and the Hospital or other Health Care Provider, and the Claims Administrator know whether the proposed health care services have been certified as Medically Necessary. The Medical Review Company will usually respond to your treating Physician or other Health Care Provider **by telephone within 3 working days (but not later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
5. If your admission or service is determined not to be Medically Necessary, you and your Physician will be given recommendations for alternative treatment. You may also pursue an appeal. See Article XVII regarding appealing a UM determination.

Failure to Precertify:

If non-Medicare-eligible Active Employees and their Dependents do not follow the Precertification Review requirements of the Plan there is a consequence. See the chart below that outlines the penalty for failure to precertify a service.

Services Requiring Precertification	Penalty for Failure to Precertify a Service
Non-emergency (elective) Hospital Admission.	• Claims will be denied. • Hospital will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed **minus a deduction of $200 from payable benefits.** • No payment for any hospital admission charges that are not retrospectively certified.
Residential Treatment Program Admission.	• Claims will be denied. • Residential treatment facility will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed. • No payment for any residential treatment program-related charges that are not retrospectively certified.
Outpatient Surgery performed in a hospital-based or free-standing surgery center.	• Claims will be denied. • Outpatient surgery facility will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed. • No payment for any outpatient surgery-related charges that are not retrospectively certified.

Services Requiring Precertification	Penalty for Failure to Precertify a Service
Epidural injections, such as a lumbar epidural steroid injection, performed in a physician office or outpatient surgery facility.	• Claims will be denied. • Provider will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed. • No payment for any epidural injection charges that are not retrospectively certified.
A cla**ss of drugs called "survival motor neuron-2 (SMN2)-directed antisense oliogonucleotides,"** which includes drugs such as Spinraza (nusinersen); or **Gene therapy.**	• Claims will be denied. • Provider will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed. • No payment for any charges that are not retrospectively certified.
Durable Medical Equipment (DME) in excess of $500.	• Claims will be denied. • Provider will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed. • No payment for any Durable Medical Equipment charges that are not retrospectively certified.
Home Health care.	• Claims will be denied. • Provider will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed. • No payment for any Home health care charges that are not retrospectively certified.
Rehabilitation therapy services including physical, occupational and speech therapy, plus cardiac and pulmonary rehabilitation.	• Claims will be denied. • No retrospective certification is permitted.
Nerve conduction study or NCS (a test to evaluate the function and electrical conduction of the motor and sensory nerves of the body to see how well and how fast the nerves can send electrical signals).	• Claims will be denied. • Provider will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed. • No payment for any Nerve Conduction Study charges that are not retrospectively certified.
Electromyogram (EMG) (a test to measure the electrical activity of muscles at rest and during contraction).	• Claims will be denied. • Provider will be instructed to contact the Medical Review Company for a retrospective certification. If the retrospective certification is approved, eligible claims will be processed. • No payment for any Electromyogram charges that are not retrospectively certified.
Certain outpatient prescription drugs obtain via a Retail Pharmacy or Mail Order Service	• Prescription will not be able to be paid under the Plan. • Contact the Prescription Drug Program for precertification of outpatient or appeal of a denial of an outpatient drug.

Questions and Answers About Hospital Admission Precertification:

How do I obtain precertification?

Certification requests should be made by phone. Call the Medical Review Company reflected in the Quick Reference Chart at the front of this document or simply remind the doctor that certification is required and ask the doctor to make the request by phone.

How will I know my admission has been precertified?

The Medical Review Company will notify the hospital admitting office before admission. You should verify precertification with the hospital or you may call the Medical Review Company's toll free phone number to check.

Who makes the certification decision?

The Medical Review Company employs nurses who use established screening criteria to make the determination. Most of the time, a nurse reviewer will provide the certification; however, if the nurse reviewer is unable to certify the admission and/or proposed procedure, the case is referred to the Medical Director.

How does the Medical Review Company know how many days to certify in advance of my hospital admission?

The initial number of days approved will be based on specific criteria used by the nurse reviewer.

How will the Medical Review Company know the number of days I actually need to be hospitalized?

The nurse reviewer will contact the hospital and/or your Physician on a regular basis to review your current status to find out if additional inpatient days are medically necessary.

Emergency Hospitalization and Notification:

If an emergency requires hospitalization, there may be no time to contact the Medical Review Company before you are admitted. If this happens, the Medical Review Company must be **notified of the hospital admission within 48 hours**.

You, your Physician, the hospital, a family member or friend can make that phone call to the Medical Review Company. This will enable the Medical Review Company to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Physician or other Health Care Providers of the various In-Network support providers and benefits available for you and offer recommendations, options and alternatives for your continued medical care.

How Concurrent (Continued Stay) Review Works:

1. When you are receiving medical services in a hospital or other inpatient health care facility, the Medical Review Company will monitor your stay by contacting your Physician or other Health Care Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the plan.
2. Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Physician or other Health Care Providers of various options and alternatives for your medical care available under this plan.
3. If at any point your stay or services are found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Physician will be notified. This does not mean that you must leave the hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay or services were not Medically Necessary, no benefits will be paid on any related hospital, medical or surgical expense.

How Case Management Works:

Case Management is a voluntary process, administered by the Medical Review Company. Its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the Fund to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling the Medical Review Company at the telephone number shown on the Quick Reference Chart in the front of this document. However, in most cases, the Medical Review Company will be actively searching for those cases where

the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the Medical Review Company will work directly with your Physician, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Non-Network Health Care Providers as needed. From time to time, the Case Manager may confer with your Physician or other Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Physician may call the Case Manager of the Medical Review Company at any time at the telephone number shown on the Quick Reference Chart in the front of this document to ask questions, make suggestions, or offer information.

Under this Plan, if during the course of case management, the Case Manager identifies opportunities that may result in savings to the member or the Fund, the Case Manager will present these opportunities to the Plan for their consideration.

ARTICLE III: ELIGIBILITY RULES FOR ACTIVE PARTICIPANTS

ESTABLISHMENT AND MAINTENANCE OF ELIGIBILITY FOR ACTIVE PARTICIPANTS AND THEIR DEPENDENTS

Section 1: Participants

All currently active participants working in covered employment for an employer who is contributing to this Fund pursuant to a legal obligation to do so and makes such contributions in accordance with the Agreement and Declaration of Trust will be eligible for so long as they **have an hour bank of at least 135 hours**. See also Article IV, Section 2 on Reinstatement After Termination of Coverage.

Section 2: Initial Eligibility

All active participants and their dependents (defined below) will be eligible for Fund benefits on the first day of the fifth (5^{th}) month following any period of three (3) consecutive months during which the active participant has worked **at least 300 hours** for which contributions have been paid by one or more participating employers, but only if at least one hour was worked during the first month of the three-month period.

Section 3: Enrollment Procedure

There are two opportunities to enroll for coverage under this Plan: Initial Enrollment and Special Enrollment. These opportunities are described further in this Article.

Procedure to request enrollment: When an employee reaches the level of hours needed to achieve Initial Eligibility for coverage, the Administrative Office will send the eligible employee an enrollment form to complete. Once you receive the enrollment form, you will need to take these steps to complete the enrollment procedures of the Plan:

a. submit a completed written enrollment form to the Administrative Office within 31 days of the date of the employee's eligibility for coverage. For dependents you are adding, the enrollment form requests the Dependent's name, social security number (SSN) or tax payer identification number (TIN) and date of birth, and
b. provide proof of Dependent status (as requested), and
c. perform steps a and b above in a timely manner.

Proper enrollment is required for coverage under this Plan. If completion of the enrollment form has been requested but the enrollment documents have not been completed and returned to the Administrative Office, claims will not be able to be considered for payment until such enrollment has been completed and submitted to the Administrative Office.

A person who has not properly enrolled by completing the Plan's enrollment procedures (noted above) including requesting enrollment in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

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

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

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

Section 4: Special Enrollment

HIPAA Special Enrollment rules require plan sponsors to extend special enrollment opportunities to certain employees and dependents if loss of eligibility for other coverage occurs (including Medicaid/SCHIP), or if the employee acquires new dependents such as through marriage, birth, adoption, or placement for adoption (the date on which you first become legally obligated to provide full or partial support of the child whom you plan to adopt).

This Plan complies with the Federal law regarding Special Enrollment by virtue of the fact that all eligible participants and their eligible dependents are automatically enrolled in this Plan as soon as the Eligibility requirements of the Plan are met. There is no option to decline medical coverage (dental and vision coverage may be declined). Individuals enrolled during Special Enrollment must have the same opportunity to select plan benefit options (when such options exist) and the same enrollment requirements, as are available to similarly-situated employees at Initial Enrollment.

If the individual requests Special Enrollment **within 31 days** of the date of the event that created the Special Enrollment opportunity, (**within 60 days** for Medicaid or a State Children's Health Insurance Program (SCHIP)), generally coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.

For more information about Special Enrollment under this Plan contact the Administrative Office.

Section 5: Lag Month

In order that there will be sufficient time for employer reports to be received and processed by the Administrative Office, a "lag month" will be used in determining your monthly eligibility. The lag month is the month between the payroll period and the month of actual coverage. For example with initial eligibility: You work 100 hours each in January, February, and March. Your total 300 hours means you will be covered as of May 1. In this example, April is the lag month.

Section 6: Dependents

Dependents means only:

a. the eligible participant's **lawful Spouse**. (A Spouse is defined as a person who is legally married under State law). The Plan requires proof of marriage. Where permissible by law, a legally separated Spouse, a domestic partner, a civil union, a common law marriage, a spouse of a Dependent Child or a divorced former Spouse of a participant is not an eligible Spouse under this Plan.); and/or

b. the employee's **natural child, legally adopted child, child placed for adoption** with the employee, (proof of adoption or placement of adoption may be requested), or **stepchild**, whether the child is married or unmarried, until the end of the month in which the child turns age 26 years.

c. a child of an eligible participant if required by a **Qualified Medical Child Support Order (QMCSO)** and if consistent with the terms of the Plan. Coverage ends at the end of the month in which the child turns age 26 years.

d. a **foster child** when placed in the eligible participant's home as a result of a court order (proof of court order may be requested), until the end of the month in which the child turns age 18 years or when the foster child relationship ends, whichever occurs earlier.

e. an <u>unmarried</u> **disabled child** age 26 and older as described in Section 7.

f. an <u>unmarried</u> child for whom the employee has **legal guardianship** under a court order (proof of guardianship may be requested) who is less than 19 years of age (or less than age 25 if a student as described below). (Coverage ends at the end of the month in which the child turns age 18 years.)

   Children under a legal guardianship must be*:*

   - less than 19 years of age; or
   - are at least 19 years but less than 25 years of age if they depend upon the eligible participant wholly for financial support and are enrolled as students in regular full-time attendance with at least 12 credit hours per semester at an accredited high school, vocational school, college or university. (Eligibility can be maintained

through the summer months by submitting proof of the next fall semester's enrollment to the Administrative Office).

- if the Plan receives a written certification from a covered child's treating physician that:

  (1) the child is suffering from a serious illness or injury, and

  (2) a leave of absence (or other change in enrollment) from a postsecondary institution is medically necessary, and the loss of postsecondary student status would result in a loss of health coverage under the Plan,

  the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the **earlier** of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan.

With respect to medical benefits, dependent children are covered from birth for expenses, for the treatment of disease, injury, congenital abnormality or hereditary abnormality, including routine nursery care furnished to a newborn child during the period of the mother's confinement in the hospital. Coverage for care in excess of normal nursery care necessary as a result of premature birth is also provided. Premature birth means the child weighed less than five pounds at birth.

See Section 7 below for eligibility information on adult disabled (incapacitated) dependents.

Note: Proof of the dependent's eligible status must be submitted to the Administrative Office prior to the submission of any claim. Failure to provide this proof will result in the denial of claims. Marriage licenses, birth certificates, adoption/divorce decrees, court orders, etc., are considered acceptable proof.

Dependent does not include any person who is in full-time service in the armed forces, a grandchild without a court ordered guardianship responsibility by the employee, retiree or spouse; a son in law or daughter in law.

If a dependent is eligible and covered both as a participant and as a dependent, the total amount of benefits payable on the dependent's behalf will not exceed the amount of expenses actually incurred for which benefits are provided under this Plan.

A newborn child is eligible at the moment of birth (proper enrollment is required in order to process claims). An adopted child is eligible:

1. on the date the child is placed in the eligible participant's home by a licensed placement agency for the purpose of adoption; or
2. on the date a petition for adoption is filed if the child has been living in the eligible participant's home as a foster child for whom foster care payments are being made.

Proper enrollment is required in order to process claims.

Section 7: Continuation of Comprehensive Medical Expense Benefits for Certain Adult Disabled (Incapacitated) Children

Medical benefits only for a dependent child will not cease solely because the child has passed the upper age limit and can be continued as a dependent so long as the individual:

1. is not capable of self-support because of mental retardation or physical disability which began before the upper age limit was reached; and
2. is unmarried and depends upon the participant (Employee, Retiree or Spouse) for financial support and maintenance.

Coverage for such an individual can be continued for the duration of the incapacity provided coverage does not terminate for any other reason. Proof of incapacity must be furnished to the Plan Administrator within 31 days after the child attains the limiting age and must be furnished thereafter as required.

A child whose coverage has terminated coverage under this Plan due to reaching the age limit, and then becomes disabled, is not eligible to re-enroll as a disabled adult dependent child under this Plan.

Section 8: Dual Coverage

If a covered person is eligible for dual coverage because he is eligible and covered both as a participant and as a dependent, the total amount of benefits payable on his behalf will not exceed the amount of expense actually incurred for which benefits are provided under this Plan.

Section 9: Effective Date of Coverage

An eligible participant's coverage will become effective on the date he becomes eligible. The coverage for each dependent will become effective on the date he/she becomes eligible.

Section 10: Continuation of Eligibility

Eligibility shall continue for an active participant and his dependents if his hour bank contains **at least 135 hours** of work credit. An hour bank is an account of work hours established for each active participant. It includes all work hours reported to the Fund for which contributions have been paid, less all hours deducted as provided below:

1. Subject to the maximum set forth in Item 3 below, all hours worked by an active participant for participating employers for which contributions have been paid will be credited to the active participant's hour bank.
2. At least **(135) hours of work credit will be deducted from an active participant's hour bank to maintain eligibility for one month**.
3. The **maximum balance in an active participant's hour bank will be 405 hours** after the 135 hour deduction has been made for the current month's eligibility.
4. In order that there will be sufficient time for employer reports to be received and processed by the Administrative Office, a "lag month" will be used in determining monthly eligibility.

Note: An active participant's hour bank will automatically be suspended as of the last day of the month if they become employed by or continue employment with a non-contributing employer. An active participant's hour bank rights will be reinstated upon their return to covered employment.

Section 11: Continuation of Eligibility While Totally Disabled

If an active participant becomes totally disabled and is prevented from working for a participating employer and the disability lasts for more than 30 days, no deduction will be made from the active participant's hour bank during the time beginning on the first day of the month in which the disability begins. In other words, the hour bank accumulation will be "frozen" and all Fund benefits will continue.

This extended coverage will continue until the first day of the month after the month in which the disability ends, or the first day of the seventh (7^{th}) month of disability, whichever occurs sooner. In order to be eligible for this continuation, the active participant must have a doctor's statement certifying the disability and must advise the Administrative Office of the disability within six (6) months of the date of the illness/injury or accident causing the disability. An active participant's hour bank may be frozen under this section for a maximum period of six (6) calendar months.

Section 12: Coordination of Benefits with Medicare

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

ARTICLE IV: TERMINATION OF ACTIVE PARTICIPANTS

Section 1: Participant and Dependent Coverage

An Active Participant's eligibility will terminate on the last day of the calendar month in which he has less than **135 credited hours** remaining in his hour bank, after deduction of 135 hours for the current month's coverage, unless the participant participates under the COBRA self-payment coverage. This self-payment provision allows a Participant to continue to be covered up to a maximum of 18 months or 29 months, if applicable, (36 months for certain dependents) by contributing the cost of the coverage on a self-payment basis as described in the "COBRA Self-Payment Coverage" Article V.

An Active Participant who retires may elect either COBRA self-payment coverage as described in the "COBRA Self-Payment Coverage" Article V, or retiree coverage (See Article VII).

NOTE: If a Participant retires and elects COBRA self-payment coverage, the Participant may not subsequently obtain retiree coverage.

- If a participant or dependent enter active military service, coverage will cease on the last day of the calendar month in which they enter active military service, unless otherwise required by law.
- A participant's coverage will terminate on the date the Plan terminates or the date of expiration of the period for which the last premium payment is made.
- If a participant's coverage terminates under the Retiree coverage, the coverage of their dependents terminates at the same time unless the dependent has lost eligibility sooner, because they no longer qualify as a dependent.

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (**a rescission**) except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact. Keeping an ineligible dependent enrolled under the Plan (for example, an ex-spouse, over age or ineligible dependent child, etc.) is considered fraud. Other situations of fraud or intentional misrepresentation of fact can include: failure to submit the required proof dependent status documentation or the documentation submitted does not confirm the dependent is eligible as a dependent for coverage under this Plan. The Plan will provide at least 30 days advance written notice to each participant who will be affected before coverage is rescinded.

Section 2: Reinstatement After Termination of Coverage

If an active participant's coverage has terminated because of insufficient credited hours, he shall again become eligible when his reserve accumulation shows a total of **at least 135 hours** within the **four calendar month period** following the date of termination of coverage. Reinstatement shall be effective on the first day of the second month which follows the month in which his requirement is met.

If an active participant is not reinstated within the four work month period, this account shall be forfeited and he shall again become eligible for coverage upon completion of the eligibility requirements set forth in the Eligibility Rules Article III. An active participant's dependents will again become eligible for coverage on the date on which he becomes eligible.

Section 3: Family and Medical Leave Act (FMLA)

In accordance with Family and Medical Leave Act of 1993 (FMLA), qualified participants may be entitled to 12 weeks (in some cases, up to 26 weeks) of unpaid leave and can continue to maintain coverage under this Plan for the duration of such leave. Contributions during the leave will be maintained on the same terms as prior to the leave. In order to qualify, the participant must meet the requirements contained in the Family and Medical Leave Act of 1993 and subsequent regulations.

Section 4: Uniformed Services Employment and Re-employment Rights Act (USERRA)

Qualified participants may be entitled to continue coverage for up to 24 months under the Uniformed Services Employment and Re-employment Rights Act in the event they are called to active military service. Additionally, if an active participant enters full-time active military duty, his hour bank can be held until such active

participant is released from active duty and returns to employment with a participating employer, if such return is within 90 days following the date of his discharge from military duty. **The participant must request that the hour bank be held and such request must be approved by the Board of Trustees**.

Section 5: Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Administrative Office has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Administrative Office (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage:

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

Paying for USERRA Coverage:

- If the employee goes into active military service for up to **31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA Self-Payment Article V for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Administrative Office in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

USERRA allows the employee to apply hours in their hour bank toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When an employee's hour bank is exhausted, the employee may pay for USERRA coverage under the self-pay rules of this plan. If the employee does not want to use their hour bank to pay for USERRA coverage, the employee can choose to freeze the hour bank and instead proceed to pay for the USERRA coverage under the self-pay rules of this plan.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Administrative Office.

ARTICLE V: COBRA SELF-PAYMENT COVERAGE
(FOR PARTICIPANTS AND THEIR DEPENDENTS)

Section 1: Overview

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), this Plan offers its participants and their covered dependents (called "qualified beneficiaries" by the law) the opportunity to elect a temporary continuation ("COBRA self-payment coverage") of the group health coverage provided by the Fund, including medical, dental, prescription drug and vision coverages, (the "Plan"), when that coverage would otherwise end because of certain events (called "qualifying events" by the law).

Qualified beneficiaries who elect COBRA self-payment coverage must pay for it at their own expense. COBRA is offered as medical only and as a package of medical/dental and vision coverage.

This Plan provides no greater COBRA rights than what is required by law and nothing in this Article is intended to expand a person's COBRA rights.

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

Other Health Coverage Alternatives to COBRA

Note that **you may also have other health coverage alternatives to COBRA available to you** that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

IMPORTANT:

The provisions in this Article outline the rules applicable to COBRA Continuation Coverage.

- These COBRA provisions are provided as notice to all covered participants and their covered spouses, and is intended to inform them (and their covered dependents, if any) in a summary fashion of their rights and obligations under the continuation coverage provisions of the law. Since this is only a summary, their actual rights will be governed by the provisions of the COBRA law itself.
- It is important that a participant and his spouse take the time to read this material carefully and be familiar with its contents.
- See also the Coordination of Benefits (COB) Article for information on how the Plan coordinates benefits when a person has multiple coverages.
- Benefits that are paid for by this Plan for Medicare-eligible Retirees and their Medicare-eligible dependents are reduced by the amounts payable under Medicare Parts A (Hospital), and B (Professional services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and B; therefore, if you are Medicare-eligible you should consider enrolling in Medicare Part A and B in order to receive the maximum amount of benefits under this Plan.

Section 2: Participant COBRA Self-Payment

If an active participant loses eligibility for Fund benefits because of insufficient credited hours in his hour bank due to termination of employment (for any reason except gross misconduct) or reduction in work hours, he and/or his eligible dependents may continue eligibility by making self-payments directly to the Administrative

Office. If the insufficiency of credited hours is due to retirement, such former active participant may be eligible to elect between coverage under these COBRA self-payment provisions or coverage under the Retiree Self-Payment Provisions of this Plan.

Section 3: Who is Entitled to COBRA Self-Payment Coverage and When?

A qualified beneficiary is entitled to elect COBRA self-payment coverage when a qualifying event occurs, and as a result of that qualifying event, that individual's health care coverage ends, either as of the date of the qualifying event or as of some later date.

"Qualified Beneficiary": Under the law, a qualified beneficiary is any participant, his spouse or dependent child who was covered by the Plan when a qualifying event occurs, and is therefore entitled to elect COBRA self-payment coverage.

- A child who becomes a dependent child by birth, adoption or placement for adoption (but not a spouse who becomes the participant's spouse) during a period of COBRA self-payment coverage is also a qualified beneficiary.
- A child of the covered employee/retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee/retiree's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
- A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

"Qualifying Event": Qualifying events are those shown in the chart below. Qualified beneficiaries are entitled to COBRA self-payment coverage when qualifying events, (which are specified in the law) occur, and as a result of the qualifying event, coverage of that qualified beneficiary ends.

- **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* employee continues working even though entitled to Medicare) then COBRA is not available.

Section 4: Maximum Period of COBRA Self-Payment Coverage

The maximum period of COBRA self-payment coverage is either 18 months or 36 months, depending on which qualifying event occurred, measured from the time the qualifying event occurs. The 18-month period of COBRA self-payment coverage may be extended for up to 11 months under certain circumstances described in the subsection on Extended COBRA Self-Payment Coverage in Certain Cases of Disability During an 18-Month COBRA Self-Payment Period that appears later in this Article. That period may also be cut short for the reasons described under the section titled "When COBRA Self-Payment Coverage May Be Cut Short" that appears later in this Article.

Who is entitled to COBRA self-payment coverage (the qualified beneficiary), when (the qualifying event), and for how long is shown in the following chart:

Section 5: Qualifying Event Causing Health Care Coverage to End	**Duration of COBRA for Qualified Beneficiaries**		
	Participant	**Spouse**	**Dependent Child(ren)**
Participant terminated (for other than gross misconduct)	18 months	18 months	18 months
Participant reduction in hours worked (making Participant ineligible for the same coverage)	18 months	18 months	18 months
Participant dies	N/A	36 months	36 months
Participant becomes divorced or legally separated	N/A	36 months	36 months
Dependent Child ceases to have Dependent status	N/A	N/A	36 months

Participant refers to the employee.

Section 6: When the Plan Must Be Notified of a Qualifying Event (Very Important Information)

In order to have the opportunity to elect COBRA self-payment coverage after loss of coverage due to a divorce, death of the participant, legal separation, or a child ceasing to be a "dependent child" under the Plan, an eligible participant and/or a family member **must inform the Plan in writing of that event no later than 60 days after that event occurs**. That notice should be sent to the Trust Fund **Plan Administrator** at their address listed on the Quick Reference Chart in the front of this document.

IF SUCH A NOTICE IS NOT RECEIVED BY THE TRUST FUND PLAN ADMINISTRATOR WITHIN THAT 60-DAY PERIOD, THE QUALIFIED BENEFICIARY WILL NOT BE ENTITLED TO CHOOSE COBRA SELF-PAYMENT COVERAGE.

Section 7: Notice of Entitlement to COBRA Self-Payment Coverage

When the Trust Fund Administrative Office determines from the employer reporting form submitted by contributing employers that an active participant's employment terminates or hours are reduced so that he is no longer entitled to coverage under the Plan or the Trust Fund Plan Administrator as stated above, is notified on a timely basis of the participant's death, divorce, legal separation, entitlement to Medicare, or that a dependent child lost dependent status, the Trust Fund Plan Administrator will give the participant and/or his covered dependents notice of the date on which coverage ends and the information and forms needed to elect COBRA self-payment coverage.

Under the law, a participant and/or his covered dependents will then have only 60 days from the date the participant and/or his dependents receive that notice, with information and forms to enable the participant and/or his dependents to apply for COBRA self-payment coverage.

IF THE PARTICIPANT AND/OR ANY OF HIS COVERED DEPENDENTS DO NOT CHOOSE COBRA SELF-PAYMENT COVERAGE WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE, THE PARTICIPANT AND/OR DEPENDENTS WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

Section 8: Coverage Provided When COBRA Self-Payment Coverage Is Elected

If a participant and/or his or her dependent(s) choose COBRA self-payment coverage, the Plan is required to provide coverage that is identical to the current health coverage that the participant had when the event occurred that caused the health coverage under the Plan to end, but the participant must pay for it. See the subsection on Paying for COBRA Self-Payment Coverage that appears later in this Article for information about how much COBRA self-payment coverage will cost the participant and about grace periods for payments of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated Participants and their families, that same change will be made to the COBRA self-payment coverage.

Section 9: Medicare Entitlement

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

Section 10: Health Coverage Tax Credit (HCTC)

The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019. For more information, visit, www.irs.gov/HCTC.

Section 11: When a Second Qualifying Event Occurs During an 18-Month Self-Payment Period

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

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

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

This extended period of COBRA self-payment coverage is not available to anyone who became the participant's spouse after the termination of employment or reduction in hours. However, this extended period of COBRA self-payment coverage is available to any child(ren) born to, adopted by or placed for adoption with the participant during the 18-month period of COBRA self-payment coverage.

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

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

Section 12: Extended COBRA Self-Payment Coverage in Certain Cases of Disability During an 18-Month COBRA Self-Payment Period

If, at any time during or before the first 60 days of an 18-month period of COBRA self-payment coverage, the Social Security Administration makes a formal determination that a participant or a covered spouse or dependent child becomes totally and permanently disabled so as to be entitled to Social Security Disability Income benefits, the disabled person and any covered family members who so choose, may be entitled to keep the COBRA self-payment coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare (whichever is sooner).

This extension is available only if:

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

b. the participant or another family member notifies the Trust Fund Plan Administrator of the Social Security Administration determination within 60 days after that determination was received by the participant or another covered family member. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, and

c. that notice is received by the Trust Fund Plan Administrator before the end of the 18-month COBRA self-payment period.

The cost of COBRA self-payment coverage during the additional 11-month period of COBRA self-payment coverage will be much higher for the disabled individual than the cost for that coverage during the 18-month period.

Section 13: Paying for COBRA Self-Payment Coverage

A. How Much COBRA Self-Payment Coverage Will Cost: By law, any person who elects COBRA self-payment coverage will have to pay the full cost of the COBRA self-payment coverage. The amount of the monthly COBRA self-payment for former participants will be established by the Board of Trustees and is subject to change at their discretion. The Fund is permitted to charge the full cost of coverage, for similarly situated participants and families (including both the Fund's and Participant's share) plus an additional 2%. If the 18-month period of COBRA self-payment coverage is extended because of disability, an additional 50% is applicable to the COBRA family unit that includes the disabled person during the 11-month period following the 18th month of COBRA self-payment coverage.

The premiums charged will represent either continuation of medical benefits only, or continuation of medical, dental, and vision benefits provided for active participants and dependents by the Fund. Each person will be told the exact dollar charge for the COBRA self-payment coverage that is in effect at the time he becomes entitled to it. The cost of the COBRA self-payment coverage may be subject to future increases during the period it remains in effect.

B. Grace Periods: The **initial payment** for the COBRA self-payment coverage is due 45 days after COBRA self-payment coverage is actually elected. If this payment is not made when due, COBRA self-payment coverage will not take effect.

After the initial COBRA payment, **subsequent COBRA premium** payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA self-payment coverage will be canceled as of the due date. Payment is considered made when it is postmarked. You will not receive an invoice for the initial payment or for the monthly payments. You are responsible for making timely payments to the COBRA Administrator listed on the Quick Reference Chart.

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

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

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

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

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

IMPORTANT

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

Section 14: Confirmation of Coverage Before Election/Payment of COBRA Self-Payment Coverage

If:

1. a health care provider requests confirmation of coverage; and
2. a participant, his spouse or dependent child(ren) have elected COBRA self-payment coverage; and the amount required for COBRA self-payment coverage has not been paid while the grace period is still in effect; or
3. the participant, his spouse or dependent child(ren) are within the COBRA election period but have not yet elected COBRA;

COBRA self-payment coverage will be confirmed, but with notice to the health care provider that the cost of the COBRA self-payment coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA self-payment coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Section 15: Addition of Newly Acquired Dependents

If, while a participant is enrolled for COBRA self-payment coverage, he marries, has a newborn child, adopts a child, or has a child placed with him for adoption, the participant may enroll that spouse or child for coverage for the balance of the period of COBRA self-payment coverage by doing so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a spouse or dependent child may cause an increase in the amount the participant must pay for COBRA self-payment coverage.

Section 16: Loss of Other Group Health Plan Coverage

If, while a participant is enrolled for COBRA self-payment coverage his spouse or dependent loses coverage under another group health plan, the participant may enroll the spouse or dependent for coverage for the balance of the period of COBRA self-payment coverage. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA self-payment coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

A participant must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount the participant must pay for COBRA self-payment coverage.

Section 17: When COBRA Self-Payment Coverage May Be Cut Short

Once COBRA self-payment coverage has been elected, it may be cut short on the occurrence of any of the following events:

1. The first day of the time period for which the amount due for the COBRA self-payment coverage is **not paid in full and on time**;
2. The date, after the date of the COBRA election, on which the covered person first becomes, entitled to Medicare;
3. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan (and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have.) IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan; or

4. The date an employer stops contributing to this Fund and establishes or starts contributing to another group health plan covering a significant number of the employer's participants formerly covered under this Plan. The new plan, established by the employer has the obligation to make COBRA self-payment coverage available to any COBRA beneficiary who was receiving coverage under this Plan on the day before the cessation of contributions, and who is (or whose qualifying event occurred in connection with) a covered participant whose last employment prior to the qualifying event was with the employer ;
5. The date the Qualified Beneficiary's lifetime benefit maximum is exhausted on all benefits (when such a lifetime maximum applies).
6. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled.
7. The date on which the Fund no longer provides group health coverage to any of its participants.

Section 18: Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early. Once COBRA coverage terminates early it cannot be reinstated.

Section 19: Appealing an Adverse Determination Related to COBRA

If an individual receives an adverse determination (denial) related to a request for eligibility for COBRA (such as with a Notice of Unavailability of COBRA), a request for extension of COBRA for a disability, a request for extension of COBRA for a second qualifying event, or a notice of early termination of COBRA, the individual is permitted to appeal to the Plan. To request an appeal, follow this process:

a) Send a written request for an appeal to the COBRA Administrator within 60 days of the date you received the adverse determination letter.

b) Explain why you disagree with the adverse determination.

c) Provide any additional information you want considered during the appeal process.

d) Include the most current name and address of each individual affected by the adverse determination.

The COBRA Administrator will respond in writing to this appeal within 60 days of the Plan's receipt of the request for appeal. The appeal response will be sent to the address provided by the individual. This concludes the COBRA appeal process.

Note that a claim for reimbursement of health expenses would follow the claim appeal processes outlined in the Claim Filing and Appeals Information Article XVII of this document.

Section 20: No Entitlement to Convert to an Individual Health Plan after COBRA Ends

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

Section 21: Whom to Contact if You Have Questions or To Give Notice of Changes in Your Circumstances (Very Important Information)

If you have any questions about your COBRA rights, please contact the COBRA Administrator at their phone number and address listed on the Quick Reference Chart in the front of this document.

Also, remember that **to avoid loss of any of the rights to obtain COBRA** self-payment coverage, you must notify the Trust Fund Plan Administrator promptly (within 60 days) and in writing at the above address if:

1. you have **changed marital status**; or
2. you have a **new dependent child**; or
3. you or a covered dependent spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration or cease to be disabled; or
4. a covered child **ceases to be a "dependent child"** as that term is defined by the Plan; or
5. you or your spouse have **changed your address**.

ARTICLE VI: ELIGIBILITY FOR EARLY RETIREE BENEFITS

Section 1: Overview:

In order for an individual to be eligible for retiree medical and vision benefits from this Trust Fund, the individual must be retired and credited with or earned a minimum of 10 years of Health and Welfare service credits under the Operating Engineers' Local No. 428 Health and Welfare Trust Fund and must have had 1,200 or more hours reported for covered employment to this Health and Welfare Fund during the 48 consecutive month period prior to the first day of the month for which retirement benefits become payable.

Note that **early retirees** are not eligible for dental plan benefits. An early retiree age 60 but under age 65 who qualifies for benefits under the Fund on an early retiree self-payment basis will be covered for medical and vision benefits only for himself and his dependents under age 65.

For the period before January 1, 1985, the individual will receive one year of Health and Welfare service credit for each year of pension credit earned under the Operating Engineers' Local No. 428 Pension Trust Fund.

For the period after January 1, 1985, the individual will receive one year of health and welfare service credit based on the following schedule:

Hours Worked in Calendar Year	Health & Welfare Service Credit
Less than 300 hours	None
300 to 599	One-quarter
600 to 899	Two-quarters
900 to 1199	Three-quarters
1200 and over	One year

Further, to be eligible the individual must be retired and receiving a pension (other than a pro rata pension) from the Operating Engineers Local No. 428 Pension Trust Fund and/or companion Annuity Trust Fund.

Retired individuals are eligible for this coverage on the later of the following dates:

- on the first day of the month for which a pension is payable; or
- after eligibility under the Hour Bank Eligibility Provisions terminate.

Notwithstanding the foregoing, the **Board of Trustees may provide retiree health benefits under this Plan to employees of newly-admitted employers** who meet the following requirements:

1. The employer has maintained a collective bargaining relationship with International Union of Operating Engineers Local 428 ("Local 428") for at least the past five years, during which the employer has provided continuous health insurance coverage to employees in the bargaining unit represented by Local 428 and their dependents.
2. The employer entered into a collective bargaining agreement on or after July 1, 2000, requiring contributions to the Operating Engineers Local 428 Health and Welfare Trust Fund on behalf of all employees performing work covered under the collective bargaining agreement with Local 428. Also, at the time the employer is admitted to participate in the Operating Engineers Local 428 Health and Welfare Plan, and on a continuous basis thereafter, the employer must pay an hourly contribution rate of not less than the rate required under the construction industry agreement between Local 428 and the Associated General Contractors Arizona Chapter, and all amendments, renewals and successor agreements.
3. The employer had not, prior to July 1, 2000, ceased making contributions to, or otherwise participating in the Operating Engineers Local 428 Health and Welfare Plan.
4. As to those employees of a newly-admitted employer who were at least 52 years of age on July 1, 2000, those eligible employees must have worked in the bargaining unit represented by Local 428 for a minimum of ten (10) consecutive years. Up to eight (8) years of employment with the newly-admitted employer may be treated as health and welfare service credits under this paragraph.

5. The employer must have been employed by, and covered under, the newly-admitted employer's previous health plan during the month prior to the month in which he or she had contributions made on his or her behalf to this Plan.
6. The employee must be eligible for, and receiving pension benefits from, the Operating Engineers Local 428 Pension Trust Fund (defined benefit and/or annuity) and/or the Pension Fund of the newly-admitted employer.
7. The employee must be retired under both the newly-admitted employer's pension plan and the Operating Engineers Local 428 Pension Trust Fund in order to qualify for retiree benefits.
8. The Board of Trustees may decline to offer retiree health coverage under this provision if they believe that admitting an employer who meets these qualifications will adversely affect the Plan.

Section 2: Coverage Available for Early Retirees Without Medicare

An early retiree age 60 but under age 65 who qualifies for benefits under the Fund on an early retiree self-payment basis will be covered for medical and vision benefits only for himself and his dependents under age 65.

Section 3: Early Retiree Self-Payment Premium

Early retirees electing to participate in the early retiree self-payment program must have their self-payments automatically deducted from their monthly pension payments by the Administrative Office in accordance with the Pension Fund provisions. Early retirees who have elected a lump sum or rollover of their Annuity benefits, and who are not receiving monthly checks from the Defined Benefits Plan, must make timely monthly payments to the Administrative Office. The amount of the self-payment premiums will be established by the Board of Trustees and is subject to change at their discretion.

Section 4: Maximum Number of Early Retiree Self-Payments

The early retirees' right to make self-payments shall be continued until the end of the month in which the earliest of the following events occurs:

1. the Trust Fund modifies this early retirement benefit or ceases providing early retirement benefits;
2. the Trust Fund ceases providing any benefits to any participant;
3. the last day of the month preceding the month for which no pension benefits are payable to the individual as a retired participant under the Operating Engineers' Local No. 428 (defined benefit) Pension Trust Fund;
4. the death of the retiree; or
5. the first day of the month in which the individual attains age 65 or becomes eligible for Medicare, if earlier.

Section 5: Extension of Eligibility for <u>Surviving Spouse and Surviving Children</u>

If termination of a Retired Employee's coverage is due to the Retired Employee's death, the retiree attains age 65 or the retiree becomes eligible for Medicare, eligibility for coverage for the surviving Spouse and Dependent Children will remain in effect until the Surviving Spouse and Surviving Dependent Children meet the termination provisions outlined below.

Termination of Eligibility for the Surviving Spouse and Dependent Children. The coverage for a Surviving Spouse and Dependent Children of a Deceased Retiree will terminate the first of the following events:

a. The **surviving Spouse's coverage will terminate <u>on the earlier of</u>** the date of any of the following reasons:
    1) the surviving Spouse remarries;
    2) failure to make the required self-payment contributions within the specified time;
    3) the surviving Spouse becomes covered under any other group policy;
    4) if the Surviving Spouse lost eligibility because the retiree attained age 65 or the retiree became eligible for Medicare, then eligibility for coverage for the Surviving Spouse will terminate when the Surviving Spouse becomes eligible for Medicare;
    5) the date the Plan is terminated.

b. The **surviving Dependent Child's coverage will terminate <u>on the earlier of</u>** the date of any of the following reasons:

1) the date the surviving Spouse's coverage terminates;
2) failure to pay the required self-pay contributions;
3) the surviving Spouse's coverage under this Plan terminates;
4) the date the Dependent Child ceases to qualify under the definition of Dependent;
5) the date of the expiration of the period of coverage for the Dependent Child as stated in the QMCSO;
6) if the Surviving Dependent child lost eligibility because the retiree attained age 65 or the retiree became eligible for Medicare, then eligibility for coverage for the Surviving Dependent Child will terminate when the Surviving Dependent Child becomes eligible for Medicare;
7) the date the Plan is terminated.

Section 6: Disability Retiree Benefit Retroactive To Medicare Eligibility

Self-payment benefits for a disability pensioner shall be made no more than 12 months retroactive from the time the individual notifies the Administrative Office of the Social Security disability award which gave rise to his disability pension.

Section 7: Payment of Self-Payment Premium for Participants, Retirees and Their Dependents

All payments must be made by check or money order. No cash will be accepted.

- The initial self-payment premium (retroactive to the date of loss of eligibility) must be paid no later than the 45th day after the date the Administrative Office is notified of the election to make self-payments. Each subsequent self-payment is due on the first day of the month for which coverage is intended.
- **There will be no invoices or reminders. You are responsible for making sure that timely payments are made to the Administrative Office.**
- **Self-payments received at the Administrative Office later than 30 days after the due date will not be accepted, and rights to self-payment will terminate. There will be no waivers granted.**

Section 8: Trustees' Rights Concerning Self-Pay Eligibles

The Board of Trustees reserves the right to request and receive from self-paying participants, early retirees and dependents any pertinent information bearing on the eligibility of such person for the benefits provided under the self-payment provisions of this Trust Fund. The failure of any such person to promptly respond to the Trustees' request for such information may lead to the self-payment rights described herein being suspended or terminated by the Trustees, at the discretion of the Trustees.

Section 9: Self-Pay Eligibles Affected By Multiple Events

Notwithstanding anything to the contrary herein, a single continuous self-pay coverage extension under the Trust Fund and Plan may not extend beyond 36 months from the end of the month in which the first event giving rise to self-payment rights occurred.

ARTICLE VII: MEDICARE CARVE-OUT BENEFIT PROGRAM
(FOR RETIREES OVER AGE 65 AND DISABILITY RETIREES ELIGIBLE FOR MEDICARE)

There are no new participants to this Medicare Carve-Out Benefit Program as of January 1, 2006.

Section 1: Overview:

The Medicare Carve-Out Benefit Program is for Medicare-eligible Retirees and their Medicare-eligible Dependents. In accordance with Medicare secondary payer rules, this Plan's covered medical benefits are payable after **any benefit is paid or payable by Medicare**.

The Medical Plan benefits for Medicare-eligible Retirees and their Medicare-eligible Dependents are described in the Schedule of Medical Benefits (Article I) in this document, and include an annual deductible, coinsurance maximum, and out-of-pocket limit that is different than applies to Active employees and their Dependents. Also, there is no requirement to use a network provider for a Medicare-eligible Retiree.

Also, Medicare-eligible Retirees and their Medicare-eligible Dependents do not receive the Active Employee Medical Plan's outpatient prescription drug coverage because Medicare-eligible Retirees and their Medicare-eligible Dependents are automatically enrolled in an insured Medicare Prescription Drug Program (PDP) coverage which covers their outpatient prescription drugs.

If a Medicare-eligible Retiree also has NON-Medicare-eligible dependents covered under the Plan, those dependents will have the same medical, dental and vision benefits as applies to dependents of Active employees, including a difference in how benefits are paid depending on the use of PPO network or Non-PPO network providers. Benefits for non-Medicare eligible dependents are described in Articles I and IX.

IMPORTANT NOTE FOR MEDICARE-ELIGIBLE RETIREES AND THEIR MEDICARE-ELIGIBLE DEPENDENTS

Benefits that are paid for by this Plan for Medicare-eligible Retirees and their Medicare-eligible dependents are reduced by the amounts payable under Medicare Parts A (Hospital), and B (Professional services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and B; therefore, **if you are Medicare-eligible you should consider enrolling in Medicare Part A and B in order to receive the maximum amount of benefits under this Plan.**

Section 2: Medicare Carve-Out Benefits for Covered Persons Eligible for Medicare

The payment of all claims will be reduced by the amount payable by Medicare, whether or not a covered person has actually enrolled for the Part B coverage. Therefore, a covered person should contact his local Social Security Office regarding enrollment as soon as possible. Benefits will be provided on a Medicare Carve-Out basis for covered persons over the age of 65, or disabled with Medicare.

Covered persons who are eligible for Medicare Carve-Out benefits receive the same Plan benefits as those described in this booklet **LESS** the benefits provided by Medicare, **regardless whether the person is actually enrolled for Medicare coverage**. This is commonly referred to as a carve-out benefit. Covered persons **not** eligible for Medicare will receive coordination of benefits like the Active Participants and their dependents who participate in this Plan.

A covered person will receive no greater benefit than a person who is not eligible for Medicare. Any Medicare payment plus the Plan payment will not equal more than the Plan allowance for any procedure. A covered person may be responsible for the applicable percentage on any given claim.

For example:

1. If the Plan pays a service at 80% and Medicare pays 80% toward a covered expense, then this Plan pays $0. The patient is responsible for the remaining 20%.
2. If the Plan pays 100% for a service and Medicare pays 80% toward the same covered service, this Plan pays 20% and the patient responsibility is $0.
3. If the Plan pays 80% for a service and Medicare pays 70% toward the same covered expense, this Plan pays 10% and the patient responsibility is 20%.

The benefits payable will be based on the Medicare approved amount. If a covered person goes to a Medicare participating physician, the physician may not bill for the difference between the billed amount and the Medicare approved amount. If a covered person goes to a non-participating physician, the physician may bill for this difference (commonly called balance billing). Therefore, benefits may be greater if a covered person goes to a Medicare participating physician.

Services provided to a Medicare enrollee for which the patient has entered into a **private contract** that exempts the practitioner from the Medicare constraints or charges **will not** be considered a covered expense for benefits under the Plan and no benefits will be payable. The amount of the self-payment premium and application forms can be obtained by contacting the Administrative Office.

Section 3: Medicare Advantage (Part C)

This Plan provides benefits that supplement benefits a covered person receives from Medicare Part A and Part B coverage. If a covered person is covered by a Medicare Advantage (Part C) program and obtains medical services or supplies in compliance with the rules of that program, including, but not limited to, obtaining all services in network when the Part C program requires it, this Plan will coordinate benefits based on the Medicare Carve-Out benefit program and will pay the benefits provided less any amounts paid by the Medicare Part C program. However, if the covered person does not comply with the rules of the Medicare Part C program, including, but not limited to, preauthorization and case management requirements, this Plan will not provide any health care services or supplies or pay benefit for services that person receives.

Section 4: Medicare Part D (for prescription drugs)

For Medicare-eligible Retirees (age 65 and older or disabled) who are covered under the Plan prior to January 1, 2006, the Plan will provide prescription drug coverage through an insured Medicare Prescription Drug Plan (PDP). Contact information for the Prescription Drug Program is listed on the Quick Reference Chart in the front of this document. This Medicare Prescription Drug Plan (PDP) benefit is not available to Medicare-eligible Retirees with an eligibility date on or after January 1, 2006, since these retirees are not eligible for this Plan.

This section outlines the fully insured Medicare Part D outpatient prescription drug benefits coverage; however, where this Article deviates from the certificate of coverage and summary of benefits produced by the Medicare Part D outpatient prescription drug program insurance company, the insurance company documents will prevail. Contact the Medicare Part D outpatient prescription drug program (whose name is listed on the Quick Reference Chart in the front of this document) for benefit information on the Medicare Part D outpatient prescription drug program.

You may get your drugs at network retail pharmacies and through the mail-order pharmacy. You may go to either preferred network pharmacies or non-preferred network pharmacies to receive your covered prescription drugs. No deductible applies to outpatient prescription drugs under the PDP drug plan.

Your share of the cost when you get a covered Medicare Part D prescription drug:

Medicare Part D Outpatient Prescription Drug Benefits		
30-34 day Supply	**Network Retail Pharmacy** for up to a 30-day supply	**Long Term Care (LTC) Pharmacy** for up to a 34-day supply
Tier 1 (Generics)	$10	$10
Tier 2 (Preferred Brands)	$52	$52
Tier 3 (Non-Preferred Brands)	$118	$118
Tier 4 (High Cost)	33% of the total cost	33% of the total cost
90-day Supply	**Network Retail Pharmacy** for up to a 90-day supply	**Long Term Care (LTC) Pharmacy** for up to a 90-day supply
Tier 1 (Generics)	$30	$18
Tier 2 (Preferred Brands)	$156	$110
Tier 3 (Non-Preferred Brands)	$354	$312
Tier 4 (High Cost)	Not applicable	Not applicable

Coverage Gap Stage: Your plan offers a reduced level of coverage through the coverage gap. You will qualify for catastrophic coverage once you reach an out-of-pocket cost of $5,000.

Catastrophic Coverage Stage: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of:

- 5% of the cost, or
- $3.35 copayment for generics (or a drug that is treated like a generic) and an $8.35 copayment for all other drugs.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

The typical number of business days after the mail-order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail-order delivery.

Section 5: No new enrollees will be accepted into the Medicare Carve-Out Program after January 1, 2006.

Section 6: Termination Provisions

Plan coverage for a person covered under this Medicare Carve-Out Benefit Program ends on the earliest of:

- the last day of the month in which the Retiree no longer meets the definition of a Retiree or is no longer eligible to participate in the Plan; or
- the last day of the month in which a person fails to make any required contributions for coverage; or
- the date of death; or
- the date the Plan is discontinued; or
- the last day of the month prior to the month in which the Retiree or covered Medicare-eligible Dependent becomes covered under a Medicare Part D Prescription Drug Plan (PDP) that is not sponsored by the Fund.

Note, there is no provision to allow a person to rejoin the Medicare Carve-Out Benefit Program once benefits under this Program terminate.

ARTICLE VIII: WEEKLY SHORT-TERM DISABILITY BENEFIT

Section 1: Overview

If an active participant becomes totally disabled due to a non-occupational injury or illness while insured for this benefit, the Plan will pay a weekly benefit amount of $100 for each full week of disability. Benefits begin the first day for injury and the eighth consecutive day for illness.

It is not necessary for the active participant to be confined to his home to collect benefits, but benefits are only payable for those days which the active participant is under the care of a legally qualified doctor. If any period for which benefits are payable is less than a full week, the Plan will pay at the rate of one-seventh of the weekly benefit for each day in such period.

All disability absences will be considered as having occurred during a single period of disability unless acceptable evidence certified by a doctor, is furnished that:

1. the cause of the latest disability absence cannot be connected with the causes of any of the prior disability absences and the latest disability absence occurs after the active participant returns to work on a full-time basis or is available for work for at least one day; or
2. the prior disability terminated and the active participant returned to work on a full-time basis for a period of at least one day, or was actually available for work on a full-time basis for one day.

Section 2: Maximum Weekly Disability Period

The maximum weekly disability period payable for any one period of non-occupational disability is 13 weeks.

Section 3: Limitations

No weekly time-loss benefit will be paid for or on account of any period of disability for which:

1. the active participant is not under the regular care of a doctor;
2. the active participant is ill or injured due to war, whether or not declared.
3. Note that there is no disability benefit available for participants who become disabled after COBRA is elected.

The disability absence must commence while coverage is in force. The weekly disability benefit is not available for retired participants.

Section 4: Definitions

"Total Disability" means that an active participant is prevented from engaging in any work for pay, profit or gain at any job for which one is suited by reason of education, training or experience. No benefits are payable for injury or illness covered by any worker's compensation or occupational disease law.

Section 5: How to File a Disability Claim

1. Obtain a disability claim form from the Administrative Office. The disability claims form needs to be completed by the participant and doctor.
2. Submit the completed disability claim form to the Administrative Office.
3. To appeal a denial of a disability claim, see the Claims Filing and Appeal Information Article XVII of this document.

ARTICLE IX: COMPREHENSIVE MEDICAL EXPENSE BENEFITS

(For Active Participants, Early (non-Medicare Eligible) Retirees and their Dependents)

Section 1: Eligible Medical Expenses

You (an eligible individual) are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expense." Eligible medical expenses are generally described in the Schedule of Medical Benefits. Eligible medical expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

1. **"Medically Necessary,"** but only to the extent that the charges are **"Allowed Charges"** (as those terms are defined in the Definitions Article of this document). The fact that a physician prescribes or orders the service does not, in itself, make it medically necessary or a covered expense; and
2. **not services or supplies that are excluded** from coverage (as provided in the Exclusions Article of this document); and
3. **not services or supplies in excess** of a Maximum Plan Benefit as shown in the Schedule of Medical Benefits; and
4. **for the diagnosis or treatment of an injury or illness** (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document); and
5. **expenses incurred while you are covered under this Plan**. An expense is incurred on the date you receive the service or supply for which the charge is made.

Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have reached the Out-of-Pocket cost-sharing limit, applicable to deductibles, copayments and coinsurance, no further cost-sharing will apply for the calendar year. The Plan also requires precertification (pre-approval) for certain services as explained in Article II.

Non-Eligible Medical Expenses: The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary, determined to be in excess of the Allowed Charge, not covered by the Plan, in excess of a Maximum Plan Benefit or payable on account of a penalty because of failure to comply with the Plan's Medical Review requirements as described later in this document.

Section 2: Deductible

The annual deductible is the amount you must pay each calendar year toward Allowed Charges, before the Plan begins to pay benefits. There are two types of annual deductibles: Individual and Family. The family deductible applies collectively to all covered persons in the same family. The deductible amount is explained on the Schedule of Medical Benefits in Article I.

- Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles, meaning that non-covered expenses or expenses in excess of Allowed Charges cannot be used to satisfy the deductible.
- Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. The amount applied to a Deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan.
- Copayments and penalties for failure to obtain precertification (preauthorization) for services do not accumulate to meet a Deductible.
- The deductible does not apply to: second surgical opinion, the hearing care benefit, In-network Preventive Care benefits, the separate accident benefit, and Outpatient Prescription Drugs (Retail or Mail Order) and Web or phone-based telemedicine consultation with a Physician through the Plan's contracted telemedicine provider.

- **Note that Medical plan deductibles are NOT interchangeable, meaning you may not use any portion of a network deductible to meet an Out-of-Network deductible and vice versa**.
- **Deductible Carryover:** Covered expenses which are incurred in the last three months of a calendar year and which are applied toward a covered person's deductible for that year shall be so applied for the next calendar year also.
- **Common Accident Provision**: During any calendar year, not more than one deductible amount will be deducted for covered expenses incurred by all the covered persons in a family due to injuries in a common accident. The term "common accident" means an accident that involves two or more covered persons of the same family.

Section 3: Coinsurance:

Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible, and any copayments required, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. The coinsurance related to a covered benefit is described on the Schedule of Medical Benefits and also in this Article.

If you use the services of a Health Care Provider who is a member of the Plan's network (a Network Provider), you will be responsible for paying less money out of your pocket.

A 100% coinsurance percentage is paid by the Plan for the following Medical Plan services:

1. Second Surgical Opinion, up to $150 per consultation.
2. Hospice, limited to terminally ill persons accessed to have life expectancy of 6 months or less.
3. Accident (limited to the first $500 per accident per person).
4. Web or phone-based telemedicine consultation with a Physician when received through the Plan's contracted Telemedicine provider (see the Quick Reference Chart).
5. Wellness/Preventive Services mandated by Health Reform.

For all other covered expenses the coinsurance percentage payable is generally as follows:

1. A covered **person resides in an area where there is a PPO network**:
    - The Plan will pay 80% of covered expenses in excess of the deductible for charges made by Preferred PPO Providers; i.e., hospital, physician, lab, etc., and other covered charges not available from a Preferred PPO Provider.
    - Should a **covered person reside in the PPO network service area and use a non-preferred (Non-PPO) provider**, reimbursement will be reduced to 50% of covered expenses after the Participant pays any applicable deductible. For use of a non-PPO emergency room for emergency services, the Plan pays emergency room services at the in-network level of benefits.
2. A covered **person resides in an area where there are NO PPO network providers (such as outside the State of Arizona)**:
    - The Plan will reimburse 80% of covered expenses which are in excess of the deductible for services obtained outside the Preferred PPO Provider area, and for services not available from a Preferred PPO Provider after the Participant pays any applicable copayment. Should a covered person travel to an area where there is a Preferred PPO Provider network, benefits will be payable in accordance with paragraph "1" above.

Section 4: Copayment (Copay)

A copayment (or copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan's copayments are indicated in the Schedule of Medical Benefits.

Copayments are to be paid in addition to your deductible. Copayments are not used to satisfy a deductible.

Section 5: Out-of-Pocket Limit

The Out-of-Pocket Limit is the most you pay for deductibles, copayment and coinsurance during a one-year period (the calendar year) before your medical plan starts to pay 100% for covered essential health benefits received from Network providers. The out-of-pocket limit amount is explained on the Schedule of Medical Benefits in Article I.

- Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
- There is no Out-of-Pocket Limit on the use of Out-of-Network providers, except that emergency services performed in an Out-of-Network Emergency Room will accumulate to meet the Network Out-of-Pocket Limit.
- The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person" annual out-of-pocket limit.
- There is a separate outpatient prescription drug out-of-pocket limit per calendar year. The combination of the Out-of-Pocket Limits for medical plan and outpatient prescription drugs will not exceed the limits set by Health Reform regulations.
- The Out-of-Pocket Limit does not include or accumulate**:**
  a. Premiums and/or contributions for coverage,
  b. Expenses for medical services or supplies that are not covered by the Plan,
  c. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for out-of-network providers,
  d. Penalties for non-compliance with the Plan's Medical Review Program requirements,
  e. Expenses for the use of out-of-network providers, except that covered emergency services performed in an Out-of-Network Emergency Room do accumulate to the In-network Out-of-Pocket Limit,
  f. Charges in excess of the Medical Plan's maximum benefits,
  g. Dental Plan and Vision Plan expenses.
  h. The Medical Plan out-of-pocket limit does not include outpatient drug expenses. The Outpatient drug out-of-pocket limit does not include medical plan expenses.

Note that the Medicare-eligible Retirees and their eligible Medicare-eligible Dependents have an annual **Coinsurance maximum** in addition to the annual Out-of-Pocket Limit, as explained on the Schedule of Medical Benefits in Article I.

Section 6: Patient Protection Rights Of The Affordable Care Act

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

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology (OB-GYN). 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 medical network at their website listed on the Quick Reference Chart.

Section 7: Nondiscrimination In Health Care

In accordance with the Affordable Care Act (also called Health Reform), to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that

provider's license or certification under applicable State law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Section 8: Covered Medical Plan Expenses

An expense is deemed to be incurred on the date the service is performed or the supply is obtained. **Certain services require precertification as explained in Article II**.

Subject to the General Exclusions Article XII, covered expenses will include only the charges for the medically necessary services and supplies listed below which:

a. are furnished to a covered person for diagnosis or treatment of an illness/injury;

b. are of the usual type furnished for such purposes;

c. do not exceed the allowed charges (as defined in this document); and

d. have been authorized by a doctor or health care practitioner and are furnished by, and fall within the scope of the authorized practice of that doctor or practitioner.

Section 9: Covered Medical Plan Expenses include (listed in alphabetical order):

1. **Accidental Injury to Teeth**.
    a. Treatment of Accidental Injuries to the Teeth: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan, all of the following conditions are met:
        - The accidental injury must have been caused by an external traumatic force and not an intrinsic force (such as the force of chewing or biting); and
        - The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
        - The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Claims Administrator for dental work.
2. **Acupuncture.**
3. **Allergy testing,** shots and serum antigen.
4. **Ambulance:** Covered expenses for licensed **Ambulance** service is limited to expense incurred to transport a covered person to the nearest facility qualified to treat the illness/injury of such person. However, no other expenses in connection with travel are included.
    a. **Ground vehicle transportation** to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency, acute illness or for inter-health care facility transfer.
    b. **Air transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status. When air/sea ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's emergency condition.
5. **Ambulatory Surgical Facility (Outpatient Surgery):** in a hospital-based or free-standing facility. Outpatient surgery **must be precertified** through the Medical Review Company as described in Article II.
6. **Blood and blood plasma**.
7. **Chemotherapy**.
8. **Diabetes Education**: Coverage is payable for a formal Diabetes Education course/program taught by a Certified Diabetes Educator and recognized as an acceptable program by the American Diabetes

Association. A diabetes education program is payable when a covered person is initially diagnosed with diabetes. A refresher course is payable once each year for up to 5 times. Benefits are payable at no charge from in-network providers only.

9. **Dialysis**. When you have reached end stage of kidney failure (renal impairment) that causes your Physician to recommend a kidney transplant or regular course of dialysis, you may be eligible for Medicare. **It is important that individuals with end stage renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**.

10. **Durable Medical Equipment:** Rental or, with the Plan's approval, the purchase of Durable Medical Equipment (DME) which is designed and used only for the treatment of Illness/Injury.

    a. Rental benefits allowed will not exceed actual purchase price. Coverage is provided for:
       - purchase of standard model equipment;
       - repair, adjustment or servicing of Medically Necessary DME is payable.
       - replacement of Medically Necessary Durable Medical Equipment is payable if there is a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense.
       - supplies that are necessary for the function of the durable medical equipment are covered only so long as the equipment is medically necessary for the individual who is ordered to use the DME and is covered under this Plan.

    b. **Diabetic glucose meters** and diabetic insulin pumps are payable as durable medical equipment. Supplies for diabetic glucose meters are payable under the outpatient prescription drug benefit. Certain supplies for diabetic insulin pumps (such as infusion sets) are payable under the medical plan, while other supplies such as insulin are payable under the outpatient prescription drug benefit.

    c. **For females who are breastfeeding**, coverage is provided for a standard manual or standard electric **breast pump**, plus the breast pump supplies needed to operate the breast pump. A hospital grade breast pump is payable if the Plan determines it to be medically necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Coverage is available at no charge from network providers only. No coverage out-of-network.

    d. **Oxygen** and the supplies for the delivery of oxygen.

    e. Durable medical equipment in excess of $500 **must be precertified** through the Medical Review Company as described in Article II.

11. **Emergency Room (ER) Visit, Urgent Care Facility Visit**

    a. **$250 copay per visit** for a PPO or Non-PPO emergency room facility in addition to the coinsurance and deductible.

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

       The Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with Health Reform regulations. See the definition of Allowed Charge or contact the medical plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers.

    b. The ER visit copay is waived if the ER visit is followed by a subsequent immediate inpatient hospital admission, results from outpatient surgery, or is due to treatment of an accidental injury received within 48 hours of the accident.

    c. **Urgent Care** Facility is payable in the same manner as a physician office visit.

12. **Endoscopy** facility use, such as for a colonoscopy.

13. **Eyeglasses or Contact Lens:** charges incurred for a contact lens or eyeglasses required immediately following and as a result of surgery to remove the lens of the eye (such as a cataract extraction).

14. **Gene therapy**. Is a technique designed to introduce human genetic material into human cells to compensate for abnormal genes or to make a beneficial protein. Gene therapy is, used to treat or prevent disease in humans by genetically altering the patient's cells to fight their disease. Gene therapy services require precertification (to avoid non-payment). See Article II for more details.

15. **Genetic testing:** Medically necessary genetic testing payable under this Plan is for:
    a. state-mandated newborn screening tests for genetic disorders;
    b. fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and 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 for pregnant women such as genetic carrier testing for cystic fibrosis;
    e. genetic testing (e.g. BRCA) and genetic counseling (no charge from in-network providers when required as a Wellness/Preventive service in accordance with Health Reform regulations).
    f. the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if all the following conditions are met:
        - the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and
        - the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and
        - the results of the test will directly impact clinical decision-making; outcome or treatment being delivered to the covered individual.

    Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor (or other qualified health care provider) and provided with regard to a genetic test that is payable by this Plan. Certain genetic counseling is payable as a Wellness/Preventive service in accordance with Health Reform regulations.

16. **Hearing Care Expense Benefit:** If an active participant, early retiree or their dependent should require treatment relating to a hearing problem, benefits will be paid for an external hearing aid up to a **maximum of $350 per ear payable during any three-year period**, as follows:

    a. The Plan will pay 80% of covered hearing expenses if a Preferred PPO Provider is used; or 50% of covered hearing expenses if a Non-Preferred PPO Provider is used, subject to any applicable copayment. There is no deductible applied to this benefit.

    b. The external hearing aid dollar limit does not apply to implantable hearing devices that function as a prosthetic device, such as a cochlear implant.

    c. Covered Hearing Expenses include an examination performed by a medical doctor, doctor of osteopathy, certified audiologist or audiometrist, and durable prosthetic devices (hearing aids) prescribed by such practitioners.

    d. A hearing exam (audiology exam) is not subject to the $350/ear benefit limit explained above.

    e. **Hearing Expenses Not Covered**: No benefits are payable for the following:
        1) examinations, not otherwise excluded under these limitations, in excess of one per ear every three years;
        2) hearing aids in excess of one per ear every three years;
        3) routine yearly examinations required by an employer in connection with the occupation of the covered individual;
        4) hearing care expense for covered services resulting from an accident, bodily injury arising out of, or in the course of, employment, or from a disease compensable under any worker's compensation, occupational disease or similar law;

5) hearing aid expense for covered services in a facility owned or operated by the federal government, or for covered services furnished for which the patient is not required to pay;
6) any expense for the repair of hearing aids;
7) hearing aid batteries.

See also the other exclusions under this Medical Plan.

17. **Home Health Care and Home Infusion Therapy:** expenses include charges made by a home health agency which are for:
    - skilled professional care comparable to such care furnished in a hospital;
    - services and supplies prescribed by a doctor for a medical reason; and
    - care reviewed and approved by the doctor at least every 30 days.

    Up to **120 visits** during any calendar year will be considered a covered expense. Each visit by the staff of a home health care team is considered as one home health care visit. Four (4) hours of home health aide service is considered as one home health care visit.

    Home health care **must** be precertified through the Medical Review Company as described in Article II.

    Home health agency expenses are **not** included as covered expenses if they are incurred in connection with any of the following:
    - services or supplies not included in the home health care plan;
    - services of a person who ordinarily resides in your home, or is a member of you or your spouse's family;
    - services of any social worker;
    - transportation services.
18. **Hospice**: Covered Hospice expenses include charges made by an inpatient hospice facility or home care hospice program that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less and to persons who are referred to hospice by the person's physician.
    a. Care which is rendered by individuals designated as volunteers, including all members of the covered person's family, is not eligible.
    b. Charges for services provided by a licensed pastoral counselor, unless provided to a member of his own congregation in the course of duties in which he has been called as a pastor or minister, are eligible.
    c. Charges for respite care and charges for bereavement counseling are available not to exceed a total of six visits for all family members and no longer than 12 months from the death of the patient. Bereavement counseling beyond that offered at no charge by a hospice provider is payable under the mental health benefits of the Plan.
19. **Hospital:** room and board, including inpatient operating room expenses.
    a. Payment not to exceed the hospital's daily semiprivate room rate; however, this limit does not apply to a unit for intensive or specialized care.
    b. Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with medically necessary dental services covered by the Dental Plan if the claims administrator determines that hospitalization or outpatient surgery facility care is medically necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this medical plan.
    c. Non-emergency Hospital Confinements (Elective Admission to a Hospital) **must be precertified** through the Medical Review Company prior to being admitted to a hospital. See Article II.
20. **Laboratory and Radiology**: Charges made for diagnostic Laboratory and Radiology tests. Certain preventive tests are covered at no charge from in-network providers as explained under Wellness/Preventive.

a. A Nerve Conduction Study (NCS) and Electromyogram (EMG) test **must be** ordered by a Physician and **precertified** through the Medical Review Company as described in Article II.

21. **Maternity expenses.**

a. **Maternity (prenatal) expenses are covered for a pregnant female employee, retiree or spouse.** No coverage is provided for ultrasounds or delivery expenses of Dependent children. The Plan covers female ACA-required preventive services and complications of pregnancy as explained in this section.

b. Certain preventive services are mandated to be covered for all females (see Wellness/Preventive later in this Article) at no charge when in-network providers are used. Under this Plan, routine prenatal obstetrical office visits and other ACA-mandated preventive services are considered to be female preventive services.

c. **This Plan provides that when one of the following complications occur, benefits for dependent children are payable** under medical expense benefits on the same basis as expenses for any other illness/injury:

- An ectopic pregnancy.
- A complication requiring intra-abdominal surgery after termination of pregnancy.
- Pernicious vomiting of pregnancy (hyperemesis gravidarum)
- Toxemia with convulsions (eclampsia of pregnancy).
- Any condition requiring hospital confinement prior to termination of pregnancy, the diagnosis of which condition is distinct from pregnancy but is adversely affected by pregnancy or caused by it, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and any similar medical and surgical condition of comparable severity, but excluding false labor, occasional spotting, doctor prescribed rest, morning sickness, pre-eclampsia, and any similar condition associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
- A pregnancy which terminates during a period of gestation in which a viable birth is not possible or which terminates in any manner other than a normal delivery.

d. This Plan complies with federal law that prohibits restricting benefits for a mother or newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section (see Article II).

e. Coverage is provided when a female participant (employee or retiree) or spouse of a male participant (employee or retiree) incurs expenses or loss, as a result of pregnancy, childbirth or miscarriage, including cesarean section or any complications arising wholly from these conditions; any pregnancy complications arising from any trauma; or for **abortion** (but only when the life of the mother would be endangered if the fetus were carried to term), and the Plan will pay in the same manner as for any other illness/injury or sickness.

f. **For females who are breastfeeding**, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes), at 100%, no deductible, when provided by a network provider acting within the scope of his/her license. Network providers are listed on the network directory described on the Quick Reference Chart. Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as explained under Durable Medical Equipment.

g. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be

required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

22. **Mental/Nervous and Substance Abuse/Substance Use Disorder (Behavioral Health Benefits).**

a. **Outpatient treatment** provided by a covered practitioner for substance abuse or mental/nervous disorders will be paid like other medical/surgical treatment. See the Schedule of Medical Benefits at the front of this document. Outpatient treatment includes outpatient office visits and other outpatient services (such as partial hospitalization/partial day care and intensive outpatient programs).

Partial Hospitalization/Partial Day Care means treatment of mental, nervous, or emotional disorders and substance abuse at a hospital (on an outpatient basis) for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period, and the care does not include an overnight stay in a hospital/facility. (More than 12 hours is considered an inpatient admission and precertification is required.)

- Partial day care is active treatment that incorporates individualized treatment plans that describe the type, frequency, and duration of services as well as coordination of services around each patient's needs. The services must require a multidisciplinary team approach under the direction of a physician and reflect structure and scheduling. Treatment goals should be measurable, functional, regularly scheduled, medically necessary, and directly related to the partial day care program.
- Patients must be under care of a physician who certifies the medical necessity of the services. Patient must be able to participate and tolerate a minimum of 20 hours per week of therapeutic services. The services must be comprehensive, structured, multimodal treatment that necessitates medical supervision and coordination due to a mental disorder (i.e., mental health diagnosis) that severely interferes with daily life.
- Partial day care should include: individual or group psychotherapy, family counseling services, patient training and education and medically necessary diagnostic services related to mental health and/or substance abuse treatment.

Intensive Outpatient Program (IOP) means providing treatment in a structured therapeutic outpatient behavioral health environment with individual and/or group counseling treatment on a schedule that is typically no less than six hours per week (e.g. counseling provided at least 2-4 hours/day or evening, and held 3-7 times a week).

- Certain intensive outpatient programs can be structured to allow an individual to be able to participate in their daily affairs, such as work or school, and then participate in IOP treatment program in the morning or at the end of the day.
- The IOP is an outpatient program and does not include an overnight stay in a facility or an inpatient hospital admission. An IOP may be appropriate for individuals who do not require medically-supervised inpatient treatment (including detoxification) and is an enhanced level of behavioral health support as compared to the standard outpatient visits that involve one 30/45/60 minute visit or two 30/45/60 minute visits per week to an outpatient behavioral health provider's office for counseling and/or medication management. Through a "step down" process, an IOP progressively transitions individuals to require less therapeutic support, to help the individual become more independent.

b. **Inpatient hospital admission and admission to a Residential treatment program** is paid like an inpatient medical/surgical admission. See the Schedule of Medical Benefits at the front of this document. Behavioral Health residential treatment program is covered (when precertified) for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. See the precertification requirements in Article II.

Residential Treatment Program/Facility/Care means an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals 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).

c. Expenses for court-ordered services are not payable unless the services are both medically necessary and are a covered benefit of the Plan.

23. **Musculoskeletal adjustment (e.g. spinal manipulation) services** payable up to an **annual maximum of 15 visits per person**, plus a maximum of 1 office visit payable per 6 months.

24. **Newborn Circumcision** is payable.

25. **Non-durable supplies** includes only the following:
    a. Sterile surgical supplies used immediately after surgery.
    b. Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
    c. Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
    d. Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under the outpatient Prescription Drug Program.

26. **Nutritional Counseling**: For services of a Registered Dietitian or licensed or certified Nutritionist, the benefit maximum is 5 visits per person per calendar year. Benefits are payable at no charge from in-network providers only. This visit limit does not apply to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health or substance abuse condition, such as an eating disorder. Certain other counseling is payable as a preventive benefit. See also the Wellness/Preventive benefits in this Article.

27. **Orthotics:** Coverage is provided for medically necessary Orthotics (items to support a weakened body part such as a knee brace) as follows:
    a. rental (but only up to the allowed purchase price of the device).
    b. purchase of standard models at the option of the Plan.
    c. repair, adjustment or servicing of the device or replacement of the device due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired.
    d. **Foot orthotics** are payable once every 12 months for adults and once in a period of 6 months for children under age 19 when replacement is required due to growth. Note that shoes and boots are not covered. Foot orthotics for adults will be allowed more frequently if there is a change in your prescription.

28. **Physicians and Health Care Practitioners**: Covered expenses include the charges made by any licensed Physician or Health Care Practitioner as defined by this Plan.
    a. Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility, outpatient/ambulatory surgery center or other covered health care facility location.
    b. Payable Physicians and Health Care Practitioner professional fees include:
        - Surgeon
        - Assistant surgeon (if Medically Necessary): payable up to 20% of the allowable charge for the primary surgeon
        - Anesthesia provided by Physicians and Certified Registered Nurse Anesthetists
        - Pathologist, Radiologist, Podiatrist (DPM)
        - Physician Assistant; Nurse Practitioner; Certified Nurse Midwife
    c. Epidural injections and certain other physician ordered services **must be precertified** through the Medical Review Company as described in Article II.

d. Plan covers charges for a **Second opinion consultation** made by a board-certified specialist for an opinion as to the need for proposed elective surgery.

e. **Electronic Visit (web or phone telemedicine consultation):** Consultation using video or teleconferencing to communicate with a Physician 24/7/365 for diagnosis and treatment of medical issues. Plan pays 100% (no deductible applies) for this service. Refer to the Quick Reference Chart for contact information for the telemedicine provider.

f. **Routine Foot Care Benefit**: Routine foot care (typically provided by a Podiatrist) is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

g. **Naturopathic medicine office visit**. No coverage for naturopathic supplies.

h. **Chiropodist office visit (often called a Podiatrist).** No coverage for supplies.

29. **Prescription Drug Benefits (Outpatient):**

a. Outpatient prescription drug coverage is available to active participants, early retirees and their dependents for FDA-approved drugs or medicines that can be obtained only with a prescription (legend drugs) by a Doctor or licensed health care practitioner. Drugs that have not yet been approved by the FDA are not covered. New FDA-approved drugs will be covered by the Plan unless the class of drug is excluded or an amendment states otherwise.

Prescription drugs play an increasingly vital role in medical treatment with the introduction of new and more powerful drugs and the success of drug therapy for many illnesses. The prescription drug benefits are designed to extend the drug coverage available under the comprehensive medical expense plan to take care of a sizeable portion of the expenses of non-hospital prescribed drugs.

The Trustees have contracted with an independent company to manage the Prescription Drug Program, whose name and address can be found on the Quick Reference Chart at the front of this document to provide discounted prescription drugs at retail network pharmacy locations.

Contact the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following:

- The list of drugs on the **Preferred Drug formulary**.
- Information on **drugs needing preapproval (precertification)** by the clinical staff of the Prescription Drug Program, such as testosterone supplements. See Article II.
- Information on which **drugs have a limit to the quantity** payable by this Plan, such as certain pain medications.
- Information on which drugs are part of the **step therapy program** (effective 2-1-12) where you first try a proven, cost-effective medication before moving to a more costly drug treatment option. Step therapy applies to certain classes of drugs, including but not limited to cholesterol lowering drugs, drugs to treat osteoporosis, stomach ulcer/heartburn treatment drugs, sleeping pills and certain arthritis/pain treatment drugs.

b. **Specialty drugs** are available on an outpatient basis through the Prescription Drug Program. Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs may need precertification, often require special handling, are date sensitive and are generally available only in a 30-day quantity.

Specialty drugs are available by contacting the Prescription Drug Program.

Specialty Drugs: $100 copay for up to a 30-day supply. Specialty drugs need to be ordered from and precertified by contacting the Prescription Drug Program. No coverage for Specialty drugs obtained from other than the Prescription Drug Program.

c. **Out-of-Pocket Limit on Outpatient Drugs**:

- The Out-of-Pocket Limit on Outpatient Drugs is the most you pay for deductibles, copayment and coinsurance during a one-year period (the calendar year) before your medical plan starts to pay 100% for covered outpatient drugs.
- Covered expenses are applied to the Out-of-Pocket Limit on Outpatient Drugs in the order in which eligible claims are processed by the Prescription Drug Program.
- The family Out-of-Pocket Limit on Outpatient Drugs accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person" annual Out-of-Pocket Limit on Outpatient Drugs.
- There is a separate medical plan out-of-pocket limit per calendar year. The combination of the Out-of-Pocket Limits for medical plan and outpatient prescription drugs will not exceed the limits set by Health Reform regulations.
- The Out-of-Pocket Limit does not include or accumulate**:**
  6) Premiums and/or contributions for coverage,
  7) Expenses for outpatient drugs that are not covered by the Plan,
  8) Charges in excess of the Allowed Charge determined by the Plan,
  9) Charges in excess of a maximum drug benefit, and
  10) Medical Plan, Dental Plan and Vision Plan expenses.

d. **Retail Pharmacy Prescription Drugs**:

1) Simply present the Operating Engineers' Local No. 428 Health and Welfare Trust Fund I.D. card to the participating network pharmacist along with the prescription to receive up to a 30-day supply for a discounted price.

   If you have questions about the **location of the nearest participating retail network pharmacy** or questions regarding the prescription drug program, you may contact the Prescription Drug Program at their name and phone number reflected on the Quick Reference Chart at the front of this document.

   Outpatient prescription drugs (a 30-day supply) are covered as follows at **network Retail Pharmacy** locations:

   - **Generic Drug**: you pay 20% of the cost of the drug to a maximum of $5.00.
   - **Formulary Brand Name Drug**: you pay 20% of the cost of the drug to a maximum of $30.00.
   - **Non-formulary Brand Name Drug**: you pay 20% of the cost of the drug to a maximum of $50.00.

2) Diabetic glucose meter supplies, prescription contraceptives and prenatal vitamins are payable under the Retail Pharmacy Prescription Drug benefits.

3) **FDA-approved contraceptives for females:** No cost-sharing for generic contraceptives submitted with a prescription when purchased at a network Retail or Mail Order location. No charge for brand prescription contraceptives only if a generic contraceptive is unavailable or medically inappropriate. The attending provider determines medical necessity for FDA-approved female contraceptives.

   No coverage for contraceptives from a Non-Network retail pharmacy.

4) **Immunizations Obtained from a Network Retail Pharmacy Location**: Certain **CDC recommended vaccinations** are payable at 100%, no cost sharing when obtained at a network retail pharmacy. Contact the Prescription Drug Program for more information (contact information listed on the Quick Reference Chart in the front of this document).

5) **Non-Network Pharmacy Use (Direct Member Reimbursement)**: For reimbursement of eligible non-network prescription drugs, send the receipt to the Prescription Drug Program at their address listed on the Quick Reference Chart in the front of this document. The eligible claim will be reimbursed as follows:

- 70% of Allowed Charges for a non-network pharmacy, and
- 80% of Allowed Charges for a non-network pharmacy when traveling or residing out of the network pharmacy area, subject to the applicable calendar year deductible.

e. **Mail Order Prescription Drugs**:

The Trust Fund also provides a mail order (home delivery) prescription drug program through the Prescription Drug Program. The mail order prescription drug program is designed for covered persons who must take long term medications as part of the treatment of such illnesses as anemia, arthritis, diabetes, heart disorders, high blood pressure and other such chronic conditions and for which a covered person's physician orders a prescription for up to 90-day intervals.

How to Use the Mail Order Prescription Plan: Ask the Administrative Office for a copy of the Prescription Drug Program's prescription brochure which outlines the necessary procedures to be followed and then just follow these easy steps:

1) Call the Prescription Drug Program's mail service patient service line at their phone number listed on the Quick Reference Chart in the front of this document.
2) Identify yourself as a participant of the Operating Engineers' Local 428 Health and Welfare Trust Fund.
3) Be prepared to give the patient service representative information about your prescription including the name of the drug, the strength, and the quantity.
4) The Prescription Drug Program's patient service representative will then give you the cost of your copayment for your prescription.
5) The 90-day supply of medication filled **through the Mail Order program:**
   - **Generic Drug:** $10 copay.
   - **Formulary Brand Name Drug**: $50 copay.
   - **Non-formulary Brand Name Drug:** $75 copay.
6) If you choose to place your order through the Prescription Drug Program, you will then complete a patient profile form and mail it to the Prescription Drug Program, along with your original prescription and applicable copayment by either check, money order, VISA, MasterCard, or DISCOVER.
7) Your order will be processed then filled by the Prescription Drug Program within 48 hours of receipt and returned by first class mail or UPS to your home. Please allow 14 days from the time you place your order for your prescription to arrive.
8) If you have any further questions regarding the Prescription Drug Program's mail order service option, please call the phone number reflected in the Quick Reference Chart at the front of this document.

f. **Coverage Of Certain Over-The-Counter (OTC) And Prescription Drugs Mandated For Coverage Under Health Reform**

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

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

The following chart outlines the OTC and certain prescription drugs that are payable by this non-grandfathered medical plan, **at no charge when purchased at the Plan's Network Retail or Mail Order pharmacy location**, in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations.

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

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters in addition to a prescription from your Physician or Health Care Practitioner:
Aspirin	• For men 45-79 years of age to reduce chance of a heart attack. For women 55-79 years of age to reduce the chance of a stroke. • For pregnant women who are at high risk for preeclampsia (a pregnancy complication). • Low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	None, if payment parameters are met	For non-pregnant adults: since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months. For pregnant women at high risk for preeclampsia: plan covers daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation. The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
FDA-approved Contraceptives for females, such as birth control pills, spermicidal products and sponges.	All females	None, if payment parameters are met	Up to a month's supply of FDA-approved contraceptives per purchase (or 3-month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the plan's Prescription Drug Program. Generic FDA-approved contraceptives are at no cost to the plan participant. Brand contraceptives are payable only if a generic alternative is medically inappropriate as determined by the Physician or Health Care Practitioner.
Folic acid supplements containing 0.4 - 0.8mg of folic acid	All females planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8 mg (400 to 800 μg) of folic acid.	None, if payment parameters are met	Plan covers generic folic acid up to one tablet per day. Excludes women over 55 years of age, and products containing more than 0.8mg or less than 0.4mg of folic acid.
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling.	None, if payment parameters are met	Since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters in addition to a prescription from your Physician or Health Care Practitioner:
Tobacco cessation products (FDA approved)	Individuals who use tobacco products.	None, if payment parameters are met	FDA-approved tobacco cessation drugs (including both prescription and over-the-counter medications) are payable under the plan's Prescription Drug Program, for up to two 90-day treatment regimens per year, which applies to all products. No pre-certification or prior authorization is required.
Fluoride supplements	For children starting at age 6 months when recommended by provider because primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a physician as preparation for a payable preventive colon cancer screening test, such as a colonoscopy for individuals age 50-75 years.
Breast cancer preventive medication	Women who are at increased risk for breast cancer and at low risk for adverse medication effects.	None, if payment parameters are met	Plan covers generic breast cancer preventive drugs such as tamoxifen or raloxifene.
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.	None, if payment parameters are met	For adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke), the Plan covers a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening (a lab test) in adults ages 40 to 75 years.

g. **What Is Not Covered Under the Prescription Drug Program?** Certain drugs are not covered as noted below:

1) OTC (over-the-counter) products, except OTC drugs mandated to be covered in accordance with Health Reform, such as aspirin.

2) Cosmetic drugs

3) Hair growth/hair removal drugs such as Rogaine/Propecia/Minoxidil

4) Male contraceptives

5) Blood components

6) Non-oral medication to treat erectile dysfunction (sexual impotency), such as injectable drugs, are not covered. Oral medication, such as Cialis, is covered.

7) Growth hormones

8) Nutritional supplements except supplements mandated to be covered in accordance with Health Reform, such as folic acid supplements.

9) Experimental drugs

10) Anorexics/appetite suppressants/diet medication

11) Legend and non-legend vitamins, except vitamins mandated to be covered in accordance with Health Reform, such as Vitamin D supplements.

12) Dental fluoride, except as mandated to be covered in accordance with Health Reform.

13) Needles and syringes, except for insulin syringes/needles

14) Surgical supplies

15) Fertility medication

h. **Information About Medicare Part D Prescription Drug Plans For Individuals With Medicare**

If an active employee and the Dependent(s) of an active employee is entitled to Medicare Part A or enrolled in Medicare Part B, they are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits. **It has been determined that the prescription drug coverage of the Medical Plan outlined in this document is "creditable."** "Creditable" means that the value of the Medical Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay.

Because the Medical Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) in order to avoid a late enrollment penalty under Medicare (explained below). You may, in the future, enroll in a Medicare Part D Prescription Drug Plan (PDP) during Medicare's annual enrollment period (generally October 15 through December 7th of each year).

You can keep your current Medical Plan and also enroll in a Medicare Part D Prescription Drug Plan (PDP) you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefit Article for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare Part D Prescription Drug Plan (PDP) you will need to pay the Medicare Part D premium out of your own pocket.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare Part D Prescription Drug Plan when first offered that enrollment opportunity, you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll for Medicare drug coverage.

Medicare-eligible individuals can enroll in a Medicare Part D Prescription Drug Plan at one of the following three times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally October 15th through December 7th); or
- for beneficiaries leaving union group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare Part D Prescription Drug Plan.

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

(Preventive Care. See Wellness/Preventive.)

30. **Prosthetics:** Artificial limbs or eyes and other non-dental Prosthetic devices (replacing a missing or non-functioning body part), which includes external prostheses when incidental to a mastectomy.

31. **Radiation therapy, Radiology services**. (see Laboratory and Radiology.)

32. **Reconstructive surgery:** procedures or treatment intended to improve bodily function and/or correct a deformity resulting from disease, infection, trauma, congenital anomaly that causes a functional defect, or prior covered therapeutic procedure.

    This Plan complies with the **Women's Health and Cancer Rights Act of 1998** (WHCRA) that indicates that for any Covered Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for certain reconstructive surgery, as follows:

    - reconstruction of the breast on which the mastectomy was performed;
    - surgery on the other breast to produce a symmetrical appearance;
    - prostheses and physical complications of all stages of mastectomy, including lymphedemas.

    These benefits are covered applying the same cost-sharing as is relevant to other medical/surgical plan benefits.

33. **Rehabilitation Therapy Services** including **physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and pulmonary rehabilitation**. The Plan covers short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician.

    a. Charges for **speech therapy** is payable when ordered by a doctor for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation, laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease.

    b. Therapy Services **must be precertified** through the Medical Review Company, see Article II.

    c. **Note:** As a reminder, the Fund's benefit program does not provide benefits for any service which is not medically necessary or for which no basic need can be adequately documented. In particular, claims for general conditioning improvement, muscle strengthening, stretching and other such exercise programs often described as rehabilitation or physical therapy are individually reviewed to determine if they constitute actual treatment and if they are medically necessary. In many instances, sufficient documentation of the need for such services cannot be demonstrated. As a result, they are not eligible for reimbursement by the Fund. The fact that a health care provider may recommend or advise the covered person to enter a program of reconditioning does not mean it is a covered expense. Therefore, before entering such a program (unless precertified), be aware of what the costs may be and decide accordingly. Each claim is evaluated on its own merits.

    d. Habilitation services, maintenance therapy and coma stimulation services are not covered.

34. **Skilled Nursing Facility:** Covered Skilled Nursing Facility expenses include charges made by a skilled nursing facilities (licensed institution other than a hospital) not to exceed **60 days per disability** which meets all of the following requirements:

    a. it must maintain on the premises all facilities necessary for medical care and treatment;

    b. it must provide such services under the supervision of doctors;

    c. it must provide nursing services by or under the supervision of a licensed registered nurse, with one registered nurse on duty at all times.

    No coverage for expenses related to a nursing home (that is not a skilled nursing facility), an assisted living arrangement or a memory care/dementia care facility.

35. **Tobacco Cessation Support:** The Plan covers, at no cost for network providers, at least two tobacco cessation attempts per person per year. A cessation attempt includes four (4) tobacco cessation counseling

sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization. FDA-approved tobacco cessation medications (including both prescription and over-the-counter medication) is payable for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

36. **Transplantation: Human organ and tissue transplants.**
    a. **Transplant services require precertification**, see Article II.
    b. Organ/tissue Procurement is payable. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. Transport fees are only payable when the organ/tissue is transported within the United States or Canada.
    c. Reasonable and necessary medical expenses incurred by a donor who is covered by this Plan, are payable without any cost-sharing applicable to those expenses.
    d. Reasonable and necessary medical expenses incurred by a donor who **is not covered** by this Plan, are payable without any cost-sharing applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.
    e. For plan participants 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.

37. **Urgent Care Facility** (see the section on Emergency Room (ER) Visit, Urgent Care Facility Visit)

38. **Wellness/Preventive Services**.
    a. The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control & Prevention (CDC). See the Schedule of Medical Benefits for payment of wellness/preventive services.

       These websites (periodically updated) list the types of payable preventive services, including immunizations:

       - https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at
       - http://www.cdc.gov/vaccines/schedules/hcp/index.html,
       - http://www.hrsa.gov/womensguidelines/ and
       - http://www.uspreventiveservicestaskforce.org/BrowseRec/Index (A and B rated recommendations).

    b. In addition to the wellness services listed on the websites above, the Plan will pay for these wellness services: well child office visits, well woman office visits, annual adult preventive exam, female contraceptives, certain over-the-counter drugs, annual screening mammogram and pap smear for females, screening colonoscopy/fecal occult blood test (FOBT)/stool DNA test for adults age 50 and older once every 10 years (colonoscopy includes bowel prep, anesthesia services & the cost of polyp removal during a screening colonoscopy), and annual prostate specific antigen (PSA) lab test for males age 40 and older.
    c. Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.

       - **In-network providers:** There is no charge for Health Reform mandated wellness/preventive services performed by in-network providers. Wellness/preventive services performed by non-network providers are paid as follows:
       - **Non-network providers:** Not covered.

    d. When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. coinsurance and deductible) for the diagnostic or therapeutic services but not for the

preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance, copay, deductible) will apply to the diagnostic or therapeutic services provided.

e. Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual cost-sharing including deductible/copay/coinsurance.

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

g. Preventive services are payable without regard to gender assigned at birth, or current gender status.

h. If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. If there is no network a provider who can provide the Health Reform required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing.

i. See page 46 for information on plan payment for certain over the counter (OTC) drugs in compliance with Health Reform.

j. As a preventive counseling benefit in compliance with Health Reform, the Plan covers the following services: for adults (1) with a body mass index of 30 kg/m2 or higher, OR (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m2) or obese (defined as a BMI of 30 kg/m2 or higher) AND have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed **intensive behavioral counseling** interventions. Intensive behavioral counseling interventions means the Plan will consider as medically necessary preventive services, up to a combined limit of 26 individual or group visits per 12-month period by a network provider. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's network pediatrician.

k. The Plan covers well woman office visits, screening for gestational diabetes, genetic counseling for females at risk for breast cancer, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, breastfeeding equipment and supplies needed to operate equipment (while breastfeeding), lactation support, no cost for coverage for tamoxifen or raloxifene for women who are at increased risk of breast cancer and low risk for adverse medication effects. These services are covered under the Wellness/Preventive Services category without cost sharing for a female when obtained from network providers.

l. **Surgical sterilization**, but not reversal of a surgical sterilization, and FDA-approved contraceptives including birth control pills/patches, diaphragms, injectables contraceptive drugs like Depo-Provera or Lunelle, intrauterine devices (IUD), cervical caps, contraceptives rings, and implantable birth control devices. Plan pays 100%, no deductible, for female sterilization performed by in-network providers. Normal cost-sharing and deductible applies to male sterilization services.

m. Coverage is provided for **FDA-approved female contraceptives** such as oral birth control pills/patch, emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring, diaphragm, implantable birth control device/service (e.g. Implanon, Nexplanon). See also page 46 for information on FDA-approved contraceptive coverage where there is no charge for generic FDA-approved contraceptives submitted with a prescription and obtained from a network pharmacy location or from the mail order service. No charge for a brand prescription contraceptive only if a generic contraceptive is unavailable or medically inappropriate. No coverage for FDA approved contraceptives obtained from a non-network retail pharmacy.

n. Certain **prenatal care/maternity related preventive care expenses are payable for all females** (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to routine prenatal obstetrical office visits.

o. The Plan covers **immunizations** recommended by both Health Reform regulations and in accordance with the Centers for Disease Control & Prevention (CDC). There is no cost-sharing when immunizations are obtained from a network retail pharmacy or during a network physician office visit.

p. **For children:** For children age 6 years and older with obesity, the Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician.

q. Coverage is provided in primary care clinician visits for fluoride varnish applied to the primary teeth of children through age 5 years.

r. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions.

ARTICLE X: SEPARATE ACCIDENT EXPENSE BENEFIT

Section 1: Overview

The Plan pays a separate accident expense benefit for expenses incurred by Active Participants, Retirees and eligible dependents for the services listed below received for the necessary treatment of a non-occupational accidental bodily injury sustained by an eligible Participant or covered dependent.

Section 2: Accident Expenses Benefit Maximum

The maximum amount payable for all injuries sustained by each covered family member through any one accident is **$500**.

Section 3: Covered Services

Covered services applicable to this accident benefit include:

1. hospital services;
2. services of a legally qualified doctor or duly licensed dentist;
3. services of a registered nurse (R.N.) other than a nurse who ordinarily resides in the covered person's home, or who is a member of the covered person's or his spouse's family;
4. professional ambulance service when used to transport the patient from the place where he is injured by an accident to the nearest hospital/facility qualified to treat the illness/injury of such person. However, no other expenses in connection with travel are included;
5. the administration of oxygen and anesthesia;
6. laboratory tests and x-ray examinations.

Section 4: Separate Accident

Separate Accident Expenses are not covered. No benefits are payable for the following:

1. treatment rendered more than 90 days after the date of the accident which caused the injury; and
2. medicines, drugs or other medical supplies not listed above.

This benefit will count against the covered person's comprehensive medical maximum benefit, but is not subject to the deductible and coinsurance features of the Plan.

This separate accident expense benefit is in excess of the amount provided under the comprehensive medical benefits of the medical Plan, subject to the Accident Expense Benefit maximum payment provided for any one accident.

ARTICLE XI: SECOND SURGICAL OPINION BENEFIT (VOLUNTARY)
(FOR PARTICIPANTS, RETIREES AND DEPENDENTS)

Section 1: Overview

There are many times when a doctor recommends non-emergency surgery, and the patient would like another doctor's opinion to be sure that the surgery is necessary. Most of us cannot judge a doctor's opinion on our own, and would welcome an additional surgical opinion before making a decision. But a second surgical opinion may be expensive and most of us do not have a second qualified surgeon whom we can contact and in whom we have confidence. This Article describes this **voluntary** second surgical opinion benefit.

Section 2: What Is Non-Emergency Surgery?

Non-Emergency surgery is surgery that is not a matter of life or death and can be performed at any time. Common examples of this are hernias, herniated spinal discs, hysterectomies, knee and joint surgery, tonsillectomies, etc.

This program does not refer to emergency surgery that must be performed immediately in order to protect the patient's health or life such as acute appendicitis, a bowel obstruction, severe fractures of bones, a collapsed lung, etc. Those types of surgeries must be performed immediately and usually are not involved in the second surgical opinion program.

Section 3: How Does The Program Work?

When you or one of your covered family members is advised to undergo non-emergency surgery, and you think you'd like a second opinion, first contact the Administrative Office. They will be able to answer questions you have concerning the program.

After you are examined, the consulting surgeon will discuss the findings with you and will advise you whether, in his opinion, an operation at this time is necessary. He will also discuss his findings with your attending surgeon unless, for some reason, you do not want him to do so.

If the second opinion is the same as your doctor's or surgeon's, you will have added peace of mind. If the second doctor advised you against the operation at the time, but you still want to proceed with it, you are free to do so, of course. THE CHOICE IS YOURS!

Section 4: Will Your Doctor Be Offended If You Want A Second Opinion?

Most doctors welcome another opinion and believe it is good idea. Surgery is an important matter to you, so your doctor will want you to feel certain you are doing the right thing if you have the operation.

Section 5: What Surgical Procedures and Medical Problems Are Suitable For A Second Opinion?

Surgery pertaining to:

- Breast
- Gall Bladder
- Dilation and Curettage
- Uterus
- Colon
- Hernia
- Heart
- Hemorrhoids
- Hip, Knee Joint
- Back
- Stomach and Duodenum
- Prostate Gland
- Tonsillectomy and Adenoidectomy
- Vascular Surgery

Section 6: If You Go Ahead With The Operation, Who Performs It?

The choice is up to you. Subject to the limitations described in this booklet, you choose the doctor and hospital you want. You can go back to your own doctor for the surgery, and he will be given the results of your consultation examination. Ordinarily, the consulting surgeon will not perform the surgery. If surgery is recommended but you do not wish to have your original surgeon perform it, the consulting surgeon will give you the names of other qualified surgeons from whom you can select.

Section 7: Will The Second Opinion Affect Your Health Coverage?

If the consulting surgeon advises against surgery at this time, but you agree with your own doctor and decide to go ahead with the operation, will that decision affect your health coverage? Absolutely not. The choice is yours, and you will always retain all the medical benefits due you.

Section 8: What If You Have Two Different Opinions?

If you are uncertain about which opinion to accept, you may make arrangements for a third surgical opinion at no expense to you. If possible, you should also arrange for the doctors to consult with each other.

Section 9: Second Surgical Opinion Benefit

The Plan will pay for a second or third opinion up to a maximum of $150 per consultation, no deductible applies. Covered expenses include charges for the consultation office visit and necessary x-ray and laboratory tests.

ARTICLE XII: GENERAL EXCLUSIONS

Section 1: General Exclusions

The General Exclusions apply to the medical plan, indemnity dental plan, hearing and vision plan benefits. Benefits shall not be payable for:

1. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** Expenses for illness/injury during or arising out of a period of employment for which worker's compensation benefits are payable, or arising from or sustained in the course of any gainful occupation or employment.
2. **War or Similar Event:** Expenses as a result of declared or undeclared act of war or any related act.
3. **Cosmetic Services Exclusions**: Expenses for reconstructive surgery unless performed as a procedure or treatment intended to improve bodily function and/or correct a deformity resulting from disease, infection, trauma, congenital anomaly that causes a functional defect, or prior covered therapeutic procedures.
4. **Custodial Care Exclusions:** Expenses for housekeeping or custodial care.
5. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical or dental services or supplies that are determined by the Plan to exceed the Allowed Charge as defined in the Definitions Article XIII of this document.
6. **No Physician Prescription**: Expenses that are not approved by a doctor.
7. **No-Cost Services:** Expenses for services rendered or supplies provided for which a covered individual is not required to pay or which are obtained without cost, or for which no charge is made if the person receiving the treatment were not covered under this Plan.
8. **Government-Provided Services:**
    a. Expenses for services that are furnished by or payable under any plan or law of any government (federal or state, dominion or provincial) or its political subdivision.
    b. Charges for treatment in a United States government hospital or elsewhere at Federal government expenses unless required by law.
9. **Expenses Incurred Before or After Coverage:** Expenses incurred while coverage is not in force.
10. **Medically Unnecessary Services:** Any charge for treatment that the Fund determines is not Medically Necessary. To determine this, the Fund may rely upon the advice of its Medical Review Company and/or an independent medical reviewer and other medical experts. This provision shall not exclude any covered medical expense that specifically states that such Treatment will be considered Medically Necessary under the Plan.
11. **Educational Services:** Educational, vocational or training supplies and services, or biofeedback, unless specifically listed as a covered benefit.
12. **Dental services** including but not limited to x-rays; treatment on or to the teeth whether done for medical or dental reasons; treatment of the gums other than for tumors; or treatment of other structures mainly involved in the treatment or replacement of teeth. Note that the medical plan does cover accidental injury to teeth as described in Article IX.
13. **Dental Service Exclusions.** Medical and dental treatment of temporomandibular joint (TMJ) dysfunction or syndrome.
14. **Prescription and Nonprescription Drugs, Nondurable Supplies and Nutrition Exclusions.** Charges for certain nonprescription (over the counter) drugs/supplies such as food supplements, except when the food supplements are the sole source of nutrition or are mandated to be covered under Health Reform; fertility drugs; male contraceptives; appetite suppressants; and appliances and devices other than disposable syringes and needles for injection of a prescribed drug, naturopathy/homeopathy or chiropodist (podiatrist) supplies. See Articles I, IX and XII for more information on what is covered and not covered under the prescription drug benefits of the Plan.

15. **Experimental and/or Investigational Services:** Expenses for experimental or investigational services, supplies or treatment.
16. **Services provided by a social worker**, except as utilized through a hospice program or as provided under covered substance abuse and/or mental/nervous disorder treatment.
17. **Durable Medical Equipment (DME):** Certain durable medical equipment is not covered such as air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, hot tubs and any other clothing or equipment which could be used in the absence of illness/injury. Charges for DME delivery, set-up or taxes are not payable.
18. Expenses resulting from **complications arising from any non-covered surgery, services or treatment** is not eligible for coverage under this Plan.
19. **Termination of Pregnancy:** Elective abortion is not covered except when medically required to save the life of the mother.
20. **Illegal Act:** Expenses incurred as a result of the commission of or the attempt to commit an assault or felony, unless such injury or illness is the result of domestic violence or is the direct result of an underlying health factor.
21. **Expenses Medicare Private Contract:** Services provided to a Medicare enrollee who has entered into a private contract that exempts the practitioner from the Medicare constraints or charges.
22. **Telephone Calls:** Charges for services rendered over the telephone from a physician or health care practitioner to a covered person, other than the covered services rendered by the Plan's contracted telemedicine provider (listed on the Quick Reference Chart).
23. **Non-Emergency Travel and Related Expenses:** Expenses for the transportation and lodging of physicians or family members of either the patient or the donor in connection with organ and tissue transplants.
24. **Hair Exclusions:** Hair transplants and other procedures or drugs to replace lost hair or to promote the growth of hair, or for hair replacement devices.
25. **Physical Fitness Exclusions.** Work hardening, weight training or similar services.
26. **Vision Care Exclusions**.
    a. Expenses for surgical correction of refractive errors and refractive keratoplasty procedure including, but not limited to radial keratotomy (RK) and automated lamellar keratoplasty (ALK) and LASIK.
    b. Charges incurred for the purchase or fitting of eyeglasses or contact lens. However, charges incurred for a contact lens or eyeglasses and frames required immediately following and as a result of cataract surgery will be a covered medical expense.
    c. Refractive testing.
27. **Services Provided Outside the United States:** Treatment or expenses incurred outside of the United States unless for an emergency.
28. **Weight Management Exclusion.** Surgical procedures for weight control or weight reduction (e.g. bariatric surgery) including surgery for excess fat in any area of the body and resection of excess skin or fat following weight loss or pregnancy.
29. **Gender Dysphoria, Transsexual, Gender Identity Services Exclusions:** Services, supplies or treatment in connection with or related to: gender dysphoria, transsexualism or issues of gender identity.
30. **Fertility and Infertility Services Exclusions.** Expenses for the diagnosis and treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, ovarian transplant, infertility donor expenses, donor egg/semen, cryostorage of egg or semen or umbilical cord blood, reversal of sterilization procedures, or adoption.

31. **Rehabilitation Therapy Exclusions:**

    a. Maintenance therapy and coma stimulation.

    b. Habilitation therapy, such as therapy services to help individuals attain certain functions that they never have acquired including delays in childhood speech and physical development.

    c. Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.

    d. Expenses for massage therapy, rolfing and related services.

    e. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and services.

    f. Expenses for **speech therapy** for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin or for childhood developmental speech delays and disorders. **Speech therapy**, except when ordered by a physician for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer radiation, laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease.

    g. Aqua therapy.

    h. Any therapy directly related to childhood developmental delays.

32. **Services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified by a Physician** as necessary for the therapeutic treatment of the covered person's disablement.

33. Expenses which you or your Dependent are **not legally obligated to pay** for; or treatment which you or you Dependent, or is entitled to obtain, under any plan or program without charge, except:

    a. Medicaid or Medi-Cal;

    b. a non-governmental charitable research Hospital in the state which makes no charge for its services in the absence of insurance; or

    c. a state Hospital, if the treatment provided would have been paid if such treatment was provided in a non-state Hospital.

34. **Foot Care:** Services for routine foot care; i.e., toenail trimming, removal of corns or calluses. However, the Plan does cover routine foot care (typically provided by a Podiatrist) is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

35. **Naturopathy and Homeopathy** supplies**.**

36. **Genetic testing and counseling** except that genetic testing is payable under this Plan is for fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women.

    a. No coverage for pre-parental genetic testing (also called carrier testing) intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents.

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

    c. No coverage for 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;

d. 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;

e. Home genetic testing kits/services are not covered.

f. Genetic testing determined by the Plan Administrator or its designee to be not medically necessary or is determined to be experimental or investigational.

37. **Prophylactic Services**: Expenses for all medical or surgical services or procedures, including prescription drugs and the use of Prophylactic Surgery as defined in the Definitions Article XIII of this document, when the services, procedures, prescription of drugs, or Prophylactic Surgery is prescribed or performed for the purpose of:

    a. avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or

    b. treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.

38. **Transplantation Related Expenses**:

    a. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.

    b. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except heart valves and kidney dialysis.

    c. Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan.

39. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, CD/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

40. **Costs of Reports, Bills, etc.:** Expenses for preparing forms, medical or dental reports/records, bills, disability/sick leave/medical/dental claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, and/or photocopying fees, or 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, lodging and travel expenses.

41. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. Expenses (past, present or future) for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Liability in Article XIX in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.

42. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, precertification is recommended in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial (see Article II regarding precertification).

43. **Long term acute care** (LTAC).

ARTICLE XIII: DEFINITIONS

Section 1: Accident: A sudden and unforeseen event as a result of an external traumatic source, that is not work-related. See also the term Injury to Teeth.

Section 2: Active Participant is an employee who, at a place other than his or her residence, works in covered employment for a contributing employer.

Section 3: Allowed Charge/Allowed Amount/Allowable Charge: means the amount this Plan allows as payment for eligible medically necessary services or supplies. The allowed charge amount is determined by the Administrative Office or the Plan to be the **lowest** of:

a. **With respect to an in-network provider** (PPO network Health Care or Dental Care provider/facility), the fee set forth in the agreement between the PPO network Health Care or Dental Care Provider/facility and the PPO network or the Plan; **or**

b. **With respect to a non-network provider within the State of Arizona**, allowed charge amount means 150% of the Medicare Allowable Rate.

c. **With respect to a non-network provider outside the State of Arizona**, allowed charge amount means 250% of the Medicare Allowable Rate.

d. Medicare Allowable Rates are the rates established and periodically updated by the Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates. Geographic area is generally defined by the first three digits of the U.S. Postal Service zip codes. The Plan may contract with a vendor to assist in determining the Medicare Allowable Rate; **or**

e. **For an air ambulance provider,** allowed charge means the lesser of the PPO fee noted above, Medicare Allowable Rate noted above, or the current Air Ambulance Rate Schedule in the state in which the air ambulance trip was initiated (e.g. the Arizona Air Ambulance Service Rate Schedule).

f. For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed charge amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**

g. The Health Care or Dental Care Provider's/facility's actual billed charge.

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

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

Any amount in excess of the "allowed charge" amount does not count toward the Plan's annual Out-of-Pocket Limits. Participants are responsible for amounts that exceed "allowed charge" amounts by this Plan.

In the case where the PPO allowed charge amount on an eligible claim exceeds the actual billed charges, the participant will pay their coinsurance on the lesser amount, the billed charges, and the Plan will pay their coinsurance on the PPO allowed charge amount, plus, the Plan will pay the participant's additional coinsurance responsibility on the difference in the PPO allowed charge amount versus the actual billed charges.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted amount. Such negotiation may be performed by the Plan Administrator or its designee. A

designee may include, but is not limited to, a Medical Review Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, In-Network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

In accordance with federal law, **with respect to emergency services performed in a Non-Network Emergency Room (ER),** the Plan's allowance for ER visit facility fees and ER professional fees is to pay the **greater** of:

a. the negotiated amount for Network providers (the median amount if more than 1 amount to Network providers), or
b. 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
c. (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

NOTE: These minimum payment standards for emergency services in a hospital emergency room **do not apply** in cases where state law prohibits a person from being required to pay balance-billed charges or where the Plan is contractually responsible for such charges. See also the definition of **emergency services** in this Article.

Section 4: Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering a Plan Participant (this term is further discussed in the COB Article XVIII of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

Section 5: Ambulatory Surgical Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

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

An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this Article, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Section 6: Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged. Amounts associated with balance billing are not covered by this Plan, even if the Plan's Out-of-Pocket Limit is reached. See also the Plan's definition of Allowed Charge. Note that amounts exceeding the Allowed Charge do not count toward the Plan's Out-of-Pocket Limit and may result in balance billing to you. Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Out-of-Network (non-PPO) Health Care Providers commonly engage in balance billing**. This means a plan participant may be billed for any balance that may be

due in addition to the amount payable by the Plan. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. **Generally, you can avoid balance billing by using In-Network PPO providers.**

Section 7: Birthing Center is a specialized facility operated by a hospital as a birthing center, and or a facility operating as a birthing center in a manner consistent with the policy statements adopted by the Governing Council of the American Public Health Association relating to birthing centers. The center must:

a. be established to manage a low-risk, normal, uncomplicated pregnancy, with delivery within a period of 24 hours from admission to the center; and
b. comply with the licensing and other legal requirements in the jurisdiction where it is located;
c. be engaged mainly in providing a comprehensive birth services program to pregnant individuals who are considered normal low risk patients;
d. have organized facilities for birth services on its premises;
e. have birth services performed by a Doctor specializing in gynecology, or at his or her direction, by a nurse midwife; and
f. have registered nurse services 24 hours a day.

A physician's office; the patient's home; a private residence; or a facility, the primary purpose of which is to perform abortions, are not considered birthing centers.

Section 8: Calendar Year is the period of 12 months starting on January 1 of each year.

Section 9: Contributing Employer is any employer that has a legal obligation to contribute to the Fund. If employed by more than one contributing employer, benefits will be no greater than if employed by only one.

Section 10: Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Administrative Office or the Plan.

Section 11: Cost-sharing: A term to mean the amount of money a plan participant is to pay toward a service or item, versus the amount of money the Plan is to pay. Plans typically have three different types of cost-sharing provisions: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these types of cost-sharing. It is common to have a Plan change the amount of its cost-sharing provisions at least once each 12 months (more often if necessary).

Section 12: Covered Person is eligible participants and their covered dependents as specified in the rules of this Plan.

Section 13: Custodial Care is care including confinement that is given due to you or your Dependent's age or mental or physical condition:

a. when there is no active plan of treatment to improve you or your Dependent's physical, functional or mental condition; or
b. when there is an active plan of treatment, but you or your Dependent has attained his or her maximum level of physical, functional or mental ability, and the active plan of treatment cannot reasonably be expected to significantly improve you or your Dependent's condition.

Custodial care includes, but is not limited to, care given primarily to help you or your Dependent in the activities of a normal daily life, such as:

a. helping to wash, bathe, move around, exercise or dress;
b. feeding, including tube or gastrostomy feeding, or preparing meals or special diets;
c. administering an enema; or supervising medication which can usually be self-administered; ors
d. acting as a companion or sitter.

Custodial care is payable only when provided as part of a covered hospice program or home health aide as part of a covered home health benefit.

Section 14: Doctor or Physician is a duly licensed doctor of medicine or osteopathy (M.D. or D.O.) authorized to perform particular medical and/or surgical services within the scope of his practice according to state law. Doctor or physician will not include an eligible participant or his dependents or any person who is the spouse,

parent, child, brother or sister of an eligible participant or his dependent. See also the definition of health care practitioner.

Section 15: Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable, is for the exclusive use of the patient, and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Section 16: Early Retiree: means a Retiree who is not yet Medicare eligible.

Section 17: Eligible Participant is an active participant, retiree, or self-payment participant that gains eligibility under the rules of this Plan.

Section 18: Employee: See Active Participant.

Section 19: Emergency Care or Emergency Treatment: Emergency care means medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a **prudent layperson** who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Services: means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).
- The term "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a **prudent layperson** who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Section 20: Experimental and/or Investigational or Unproven: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven.

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

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

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the Plan for the course of medical treatment that is under investigation) or consent document (the consent form

signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;

2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational or unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.
5. Note that under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. See precertification in Article II.

   The routine costs that are covered by this Plan are discussed below:

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

   b. An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial including a clinical trial titled as a pilot study conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial including a clinical trial titled as a pilot study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control & Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

c. The plan may require that an eligible individual use an In-Network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

d. The plan may rely on its Medical Review Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See the Claim Filing and Appeal Information Article XVII for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

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

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Centers for Disease Control & Prevention (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the U.S. such as Aetna, Anthem, CIGNA, or United Healthcare, or MCG Care Guidelines, formerly Milliman Care Guidelines, or the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines or, the clinical decision support resource titled "UpToDate," or, the American Dental Association (ADA) with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

To determine how to obtain a Precertification of any procedure that might be deemed to be Experimental and/or Investigational or Unproven, see Precertification in Article II.

Section 21: Fund is the Operating Engineers' Local No. 428 Health and Welfare Trust Fund; and Fund also is the Board of Trustees established by the Trust Agreement where applicable.

Section 22: Gene Therapy: is a technique that uses human genes to treat or prevent disease in humans. Gene therapy involves introducing human DNA into an individual to treat a genetic disease. The new DNA usually contains a functioning gene to correct the effects of a disease-causing mutation. The technique can allow doctors to treat a disorder by inserting a gene into an individual's cells instead of using drugs or surgery. There are several approaches to gene therapy, including:

a) Replacing a mutated "faulty" gene that causes disease with a healthy copy of the gene.
b) Inactivating, or "knocking out," a mutated "faulty" gene that is not functioning properly.
c) Introducing a new gene into the body to help fight a disease or cure the disease.

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

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

Section 23: Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Section 24: Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Section 25: Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Section 26: Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services include physician-prescribed therapy for a child who is not walking or talking at the expected age.

Section 27: Health Care Provider is any of the institutions or persons listed here engaged in providing medical care or diagnostic treatment to sick or injured persons: Hospital, Laboratory, Doctor, Health Care Practitioner, Birthing Center, Ambulatory Surgical Center, Home Health Agency, Licensed Ambulance Services, Hospice, Skilled Nursing Facility.

Section 28: Health Care Practitioner means a Physician, Chiropractor, Chiropodist, Dental Hygienist, Dentist, Nurse, Nurse Practitioner, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, Naturopath, Homeopath, Certified Nurse Midwife, Acupuncturist, Optometrist, Optician who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

A health care practitioner for mental/nervous disorders and/or substance abuse (behavioral health) includes: a psychiatrist, psychologist, or a certified mental health or substance abuse counselor or social worker who has a master's degree or Ph.D. and who:

1. is legally licensed and/or legally authorized to practice or provide service, care or treatment of mental/nervous disorders under the laws of the state or jurisdiction where the services are rendered; and
2. acts within the scope of his or her license; and
3. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Section 29: Home Health Agency is a licensed public or private agency that meets all of the following tests:

1. it is primarily engaged in providing skilled nursing and other therapeutic services;
2. its policies are set by a professional group associated with the agency to govern the services provided; and
3. it maintains records for all patients.

Section 30: Hospice is an agency that provides medical, health care services and medical social services for the palliative and supportive care and treatment of terminally ill individuals. The agency must:

1. provide 24 hour, 7 day a week service;

2. provide a program of services under direct supervision of a doctor or licensed R.N.;
3. maintain full and complete records of all services provided to all covered persons; and
4. be established and operated in accordance with the applicable laws or regulations of the jurisdiction in which it is located.

Section 31: Hospital is a public or private facility, licensed and operating according to the law, is accredited by The Joint Commission (TJC), and which provides care and treatment by doctors and nurses on a 24-hour basis for an illness/injury through the medical, surgical and diagnostic facilities on its premises. A hospital does not include a facility or any part thereof which is a place for rest, the aged, convalescent care. A Hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to state law. The requirement that a Hospital must provide surgical and/or diagnostic facilities does not apply to facilities for mental, nervous and/or substance abuse treatment.

Section 32: Hospital Confinement is confinement in a hospital as a registered bed patient.

Section 33: Hour Bank is an account of credited hours established for each active participant.

Section 34: Illness/Injury is bodily injury or sickness, or congenital defects or birth abnormalities, including premature birth for which more than routine nursery care is required. For the purposes of this Plan, a pregnancy or complications of a pregnancy, of an eligible participant or participant's spouse will be considered an illness/injury. The Plan does not pay for delivery expenses associated with a pregnant dependent child.

Section 35: Injury to Teeth: An injury to the teeth caused by an external traumatic force and not an intrinsic force (such as the force of chewing or biting).

Section 36: Medical Expense Benefits are the benefits payable under this Plan for necessary medical expenses incurred by you or your dependent.

Section 37: Medically Necessary means a medical or dental service or supply will be determined to be "medically necessary" by the Board of Trustees or its designee if it:

- is provided by or under the direction of a physician who is authorized to provide or prescribe it and
- is determined by the Board of Trustees or its designee to be necessary in terms of generally accepted medical standards (in the community in which it is provided); and
- is determined by the Board of Trustees or its designee to meet all of the following requirements:
  a. it is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
  b. it is not provided solely for the convenience of the patient, physician or hospital; and
  c. it is an "appropriate" service or supply given the patient's circumstances and condition; and
  d. it is a "cost-efficient" supply or level of service that can be safely provided to the patient; and
  e. it is safe and effective for the illness or injury for which it is used.

A medical or dental service or supply will be considered to be "appropriate" if:

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

  a. A medical or dental service or supply will be considered to be "cost-effective" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

  b. The fact a patient's physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical (or dental) coverage provided by the Plan.

  c. A hospitalization will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

d. A medical or dental service or supply that can safely and appropriately be furnished in a physician's office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or other more costly facility.

e. The non-availability of physicians or alternatives to provide medical services will not result in a determination that continued confinement in a hospital is medically necessary.

f. A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a physician, or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, or any hospital.

Section 38: Medicare is the Part A, Part B, Medicare Advantage Part C or Part D Plans described in Title XVIII of the United States Social Security Act, as amended.

Section 39: Medicare-eligible Retiree: means a Retiree who is also entitled to Medicare coverage.

Section 40: Mental/Nervous Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Section 41: Non-occupational as applied to any injury or sickness means:

- any injury not arising out of or in the course of any employment for wage or profit; or
- any sickness not entitling the person who has contracted the sickness to benefits under worker's compensation or occupational disease law.

Section 42: Participant: See Eligible Participant.

Section 43: Physician: see Doctor.

Section 44: Placed for Adoption: A child is "Placed for Adoption" with the active participant/retiree on the date the active participant/retiree first becomes legally obligated to provide full or partial support of the child whom the active participant/retiree plans to adopt.

Section 45: Plan is the program, benefits and provisions described in this document, as adopted by the Board of Trustees and amended from time to time.

Section 46: Plan Administrator/Plan Sponsor: The Board of Trustees of Operating Engineers Local No. 428 Health and Welfare Trust Fund and who have the responsibility for overall Plan administration.

Section 47: Plan Year: is October 1 through September 30.

Section 48: Practitioner: see the definition of Health Care Practitioner.

Section 49: Pregnancy: includes miscarriage or childbirth.

Section 50: Physician: see definition of Doctor.

Section 51: Precertification: Precertification is a review procedure performed by the Medical Review firm or the Prescription Drug Program **before** services are rendered, to assure that health care services (including certain drugs) meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and Medically Necessary. Precertification is also referred to as precert, pre-service review, prior authorization, prior auth, preauthorization, pre-admission review, prior approval or preapproval. See Article II for precertification information.

Section 52: Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease.

Section 53: Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on therapy to help an individual attain certain functions that have never have acquired, such as speech therapy to assist a child in learning to talk. See also the definition of Habilitation.

See the Schedule of Medical Benefits in Article I and the Exclusions Article XII of this document to determine the extent to which Rehabilitation Therapies are covered.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

Section 54: Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required contributions or self-payments. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

Section 55: Residential Treatment Program/Facility/Care: is an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a residential treatment facility (licensure requirements for this residential level of care may vary by state).

Section 56: Retiree is any person who meets the eligibility requirements for retirement benefits under the Health and Welfare Plan as established by the Fund and as amended from time to time. The Plan recognizes Early (non-Medicare eligible) Retirees and Medicare-eligible Retirees. Refer to Articles VI and VII.

Section 57: Self-Payment Participant is any person who meets the eligibility requirements for self-payment under the Health and Welfare Plan as established by the Fund and as amended from time to time.

Section 58: Skilled Nursing Care is services performed by a licensed health care professional that meet the following:

a. Ordered and provided under the direction of a doctor.
b. Are intermittent and part-time (nursing service duration not to exceed 16 hours per day typically on less than a daily basis).
c. Require the skills of technical or professional personnel (e.g., R.N., L.P.N.) in that the service is so inherently complex that it can be safely and effectively performed only by or under the supervision of this technical/professional individual.

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

Section 59: Skilled Nursing Facility is a licensed institution (other than a hospital, as defined) which meets all of the following requirements:

- it must be eligible to qualify as a skilled nursing facility and as a provider of services under Medicare;
- it must maintain on the premises all facilities necessary for medical care and treatment;
- it must provide such services under the supervision of doctors;
- it must provide nursing services by or under the supervision of a licensed registered nurse, with one registered nurse on duty at all times;
- it operates primarily for the skilled nursing care and rehabilitation of sick or injured persons as inpatients;
- it is not, other than incidentally, a place of treatment for alcohol/drug abuse or the mentally ill, an assisted living care facility, memory care/dementia care facility.

Section 60: Substance Abuse is a person's use of any drug or alcohol agent that interferes with the person's physical, psychological, social ability or performance. Interference with a person's ability to perform his job and/or satisfactorily interact with co-workers because of the use of any drug or alcohol agent is specifically included within this definition of substance abuse. The amount of time which may pass between a person's use of any drug or alcohol agent and the manifestation of any effects of such use is immaterial.

Section 61: Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan's benefit:

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

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

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

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

Section 62: Telemedicine: the remote diagnosis and treatment of patients by means of telecommunications technology. Physicians are available for web or phone-based consultation, including diagnosis and treatment of medical and/or mental health issues. The Plan's telemedicine provider is listed on the Quick Reference Chart.

Section 63: Totally Disabled and Total Disability, as determined by a doctor, is unable, because of illness/injury:

a. as an eligible active Participant, to work for pay, profit or gain at any job for which one is suited by reason of education, training or experience; or

b. as any other covered persons, to engage in one's regular and usual activities and not working at any job for pay, profit or gain.

Section 64: Transplant, Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

Section 65: Treatment. A Treatment or course of treatment which is ordered and/or provided by a Doctor to diagnose or treat an Injury or Illness, including confinement and inpatient or outpatient services or procedures, and drugs, supplies, equipment, or devices. The fact that a treatment was ordered or provided by a Doctor does not, of itself, mean that the treatment will be determined to be Medically Necessary.

Section 66: Work Related Illness/Injury is an illness/injury which arises from, or is sustained in, the course of work for pay, profit or gain.

ARTICLE XIV: DENTAL PLAN BENEFITS

Section 1: Overview

The Plan offers eligible Active participants and dependents the option of choosing between two dental plans: a prepaid plan and an indemnity plan. These dental plans are discussed in detail in this Article. Dental benefits are **not available** to Early Retirees or Medicare-eligible Retirees.

Dental Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA.

Individuals are permitted to opt out of dental plan coverage by contacting the Administrative Office.

Section 2: Highlights of the Dental Plan Benefits

See also the applicable dental exclusions.

Dental Plan Options	Indemnity Dental Plan	Prepaid Dental Plan
CALENDAR YEAR DEDUCTIBLE (Not applicable to Preventive Services)	$50/person $150/family	None
Preventive Dental Services	80% of the Allowed Charge, no deductible	100% after copay
Basic Dental Services	80% of the Allowed Charge, after deductible met	100% after copay
Major Dental Services	60% of the Allowed Charge, after deductible met	100% after copay
Maximum Dental Benefit per Person per Calendar Year	$2,000 per year for individuals age 18 and older. No maximum for children under age 18 years.	None

Section 3: Prepaid Dental Plan Benefits

The Fund provides a fully insured Prepaid Dental Plan whose name and address are listed on the Quick Reference Chart in the front of this document. Under this benefit, a covered person receives comprehensive benefits through a network of Plan dentists. This Article highlights some of the benefits of this prepaid plan but for more detailed information, refer to the Evidence of Coverage and documents provided to you by the prepaid dental plan.

This section outlines the fully insured Prepaid Dental Insurance coverage; however, where this section deviates from the certificate of coverage and summary of benefits produced by the dental insurance company, the insurance company documents will prevail. Contact the Prepaid Dental insurance company (whose name is listed on the Quick Reference Chart in the front of this document) for a copy of additional dental insurance benefits.

A. Selecting a Network Dentist

To receive dental services you and each member of your family who elects prepaid dental benefits must select a participating dentist from the Directory of Dentists participating in the Prepaid Dental Plan. Each family member may choose a different dentist. You may change your dentist throughout the year. The directory of dentists is available at no cost from the Prepaid Plan or at their website listed on the Quick Reference Chart.

B. Dental Emergency

Except in the case of a dental emergency, payment for all services received from a **non-Plan Dentist** will be the responsibility of the plan participant. A **dental emergency** under this prepaid plan means those dental services necessary to control bleeding, relieve pain, including local anesthesia, or eliminate acute infection. Medications that may be prescribed by a Dentist are not covered.

C. Copay Applies to Prepaid Dental Services

Once the copay for each service has been met, benefits are paid at 100%, there are no claim forms. For a list of the copays that apply to each dental service, contact the Prepaid Dental Plan at their phone number listed on the Quick Reference Chart in the front of this document.

D. Enrollment

A covered person may request an enrollment form, Directory of Dentists participating in the Prepaid Plan and the Dental Plan brochure describing the benefit/copayment schedule from the Administrative Office, at no cost.

E. Prepaid Dental Benefit Limitations and Exclusions

The following are limitations and/or exclusions under the prepaid dental plan:

1. Routine cleanings are limited to once every six (6) months, unless medically necessary.
2. Medical costs associated with dental procedures are not covered.
3. The parent or guardian is responsible for affecting behavior of dependents so that provider may safely render proper dental care. Services rendered by a specialist because of behavior adjustment may affect the participant's out of pocket expense. Such services needed may be physical restraints, sedation or other method of control.
4. Dentures or appliances will be replaced only after five years since dentures or appliances were provided by Plan. If denture or appliance becomes unserviceable due to illness or causes not controlled by ordinary means, the following will apply: Replacement will be made only if existing denture or appliance cannot be made serviceable.
5. Replacement of dentures, appliances or bridgework due to loss or theft is not covered.
6. Dental treatment provided or started prior to the participant's eligibility to receive benefits is not covered. Dental treatment started after the participant's termination is not covered.
7. Failure to follow prescribed treatment may result in additional charges. Accidents occurring during the course of any treatment may result in additional charges.
8. Restorations and endodontic posts and cores placed after root canal therapy are separate procedures from actual root canal treatment. Therefore, the specific copayments listed for restorations or posts and cores will apply.
9. Orthodontic treatment is limited as follows:
    a. Minor treatment of tooth guidance/interceptive orthodontia is limited to eighteen (18) consecutive months.
    b. Retention treatment is limited to eighteen (18) consecutive months. Ongoing treatment past eighteen (18) months is not covered. Also, ongoing treatment past eighteen (18) consecutive months may be subject to additional fees. This would be determined as outlined in the Copayment Schedule and determined by provider.
10. Orthodontic treatment involving therapy for myofunctional problems, T.M.J. dysfunctions, micrognathia, macroglossia, cleft palate or hormonal imbalances causing growth and developmental abnormalities, is not covered.
11. Extractions for Orthodontic purposes only are at a 25% discount off of Plan Provider's normal retail charge.
12. Orthodontic cases, involving orthognathic surgery are not covered.
13. Treatment for malignancies, neoplasms or cysts, including biopsy, is not covered.
14. Except in the case of a dental emergency, services provided by non-Plan dentists are not covered unless preauthorized by Plan.

15. Copayments listed for restorations do not include the cost of lab fees.
16. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure lost by attrition are not covered.
17. Fixed prosthetic restoration of six (6) or more existing teeth when performed as a simple procedure as part of a complete oral rehabilitation or reconstruction is not covered.
18. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restoration and/or appliances is not covered.
19. Dental treatment is not covered if the participant's general health or physical limitations prevent provider from rendering appropriate dental treatment.
20. Costs associated with prescriptions or over the counter medications are not covered.
21. Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.
22. The surgical removal of implants or any surgery required to adjust, replace, or treat any problem related to an existing implant, or implant appliance, is not covered.

Section 4: Indemnity Dental Plan Benefits

The indemnity dental plan will provide benefits based on allowed charges subject to the calendar year deductible and maximum benefits stated in the Summary of Indemnity Dental Benefits. You may use any licensed dental provider; however if you use the services of a dental provider under contract to the Indemnity Dental Plan Administrator (called an in-network or PPO dentist) you will receive a discount off your eligible dental services. For a list of network dental providers (at no charge) contact the Dental Plan Administrator whose name and phone number are listed on the Quick Reference Chart in the front of this document.

A. Indemnity Dental Plan Calendar Year Deductible

The calendar year deductible is $50 per person and $150 per family. The calendar year deductible will apply to all services except preventive care dental expenses.

B. Indemnity Dental Plan Benefit Percentage

This Plan will pay the following allowed charges for the service classifications indicated:

C. Indemnity Dental Benefit Percentages	
Preventive Services	100% of the Allowed Charge, no deductible
Basic Services	80% of the Allowed Charge, after deducible met
Major Services	60% of the Allowed Charge, after deductible met

D. Indemnity Dental Plan Maximum Dental Benefit

The maximum benefit payable under the dental benefit applicable to each covered person is $2,000 per calendar year for all preventive, basic or major services combined for individuals age 18 and older. The Indemnity Dental Plan Maximum does not apply to children under age 18 years. Note there are no orthodontia benefits under this Plan.

E. Indemnity Dental Plan Allowed Charges

For purposes of determining payable benefits under this Indemnity Dental Plan, the Allowed Charges will be determined according to the definition of Allowed Charges as noted in Article XIII.

F. Indemnity Dental Plan Covered Services

Preventive Services

1. **Diagnostic:** The necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment.
2. The necessary procedures to prevent the occurrence of oral disease. These services include:
   a. prophylaxis - once each six months;
   b. topical application of fluoride solution to age 18; and
   c. space maintainers, to age 19.
3. **X-rays:** Complete mouth x-rays are covered benefits only once in a three-year period, unless special need is shown. Supplementary bitewing x-rays are covered benefits upon request of dentist, but not more than once every six months.

Basic Services

1. **Oral Surgery:** The necessary procedures for extractions and other oral surgery including pre- and postoperative care.
2. **Restoration Dentistry:** The necessary procedures to provide amalgam, composite resin or plastic restorations for treatment of carious lesions. (Gold restorations, crowns and jackets, except stainless steel crowns, are covered under Major Services.)
3. **Endodontics:** The necessary procedures for pulpal therapy and root canal filling on non-vital teeth.
4. **Periodontics:** The necessary procedures for treatment of the tissues supporting the teeth.
5. **Sealants:** Payable for dependents up to age 19.

Major Services

1. **Prosthodontics**: The necessary procedures for construction of bridges, partial and complete dentures.

   Replacement will be made of an existing prosthodontic appliance only if it is unsatisfactory and cannot be made satisfactory.

   Prosthodontic appliances (including partial and complete dentures, crowns and bridges) will be replaced only after five years have elapsed following any prior provision of such appliances.

   a. Veneers or porcelains posterior to the second bicuspids are considered optional and, as such, are not covered services. An allowance will be made for cast restorations.
   b. Fixed prosthetics and/or partials are not a benefit for children under age 16. An allowance will be made for a temporary acrylic partial. A posterior fixed prosthetic appliance is not a covered service when done in connection with a removable appliance in the same arch.
   c. Porcelain, gold, porcelain veneer and acrylic veneer precious metal crowns over vital teeth are not covered services for children under age 12. An allowance will be made for an acrylic crown.

   Optional Services: In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the Plan will pay the applicable percentage of the lesser fee. The patient is responsible for the remainder of the dentist's fee.

   Partial Dentures: The Plan will provide a standard chrome or acrylic partial denture or will allow the cost of such procedure toward a more complicated or precision appliance that the patient and dentist may choose to use.

   Complete Dentures: If in the construction of a denture, the patient and dentist decide on personalized restorations or employs specialized techniques as opposed to standard procedures, the Plan will allow an appropriate amount for the standard denture toward such treatment, and the patient must bear the difference in cost.

   Occlusion: The Plan will allow an appropriate amount for procedures necessary to replace missing teeth. Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the patient. Such procedures include, but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from attrition, and restoration for malalignment of the teeth.

Implants: If implants are utilized, the Plan allows the cost of standard complete or partial dentures toward the cost of implants and appliances constructed in association therewith. The Plan will not provide surgical removal of implants.

2. **Restorative Crowns and Inlays:** The necessary procedures for provision of crowns, jackets, inlays or gold restorations (except stainless steel crowns which are covered under Basic Services) when teeth cannot be restored with amalgam, composite resin or plastic materials.

   Plastic or composite resin restorations posterior to the second bicuspids are optional and not a covered benefit. An allowance equal to that for silver amalgam restoration will be made in such cases.

G. Indemnity Dental Plan Benefit Exclusions

The Plan excludes those services that may be classified as:

1. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** Services for injuries or conditions which are compensable under worker's compensation or employer's liability laws; services which are provided the covered person by any federal or state government agency or are provided without cost to the covered person by a municipality, county or other political subdivision or community agency.
2. **Surgical services with respect to congenital or developmental malformations or cosmetic surgery or dentistry** for purely cosmetic reasons. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and anodontia.
3. **Benefits are not provided for prosthodontic appliances or devices** (including crown and bridge) or any single procedure started prior to the date the patient becomes eligible for such services under this contract.
4. **General anesthesia**, except when administered for a covered oral surgery procedure performed by a dentist.
5. **Prescription drugs**.
6. **Temporomandibular Joint Dysfunction** (TMJ).
7. **Orthodontic services**.
8. **Oral hygiene instruction and dietary instruction** and **Plaque control programs**.
9. Myofunctional therapy.
10. Charges for **hospital services**.
11. **Hypnosis**.
12. **All other services not specified as covered dental services**.
13. **Government Provided Services:** Charges for treatment in a United States government hospital or elsewhere at federal government expense unless required by law.
14. Dental **treatment received outside the U.S**.
15. **Costs of Reports, Bills, etc.:** Expenses for preparing medical and dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls and/or photocopying fees.
16. **Experimental and/or Investigational Services:** Expenses for experimental or investigational services, supplies or treatment.
17. **Education Services and Home Use Supplies:** Expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss, etc.

H. Indemnity Dental Plan Coordination of Benefits (COB)

Indemnity Dental benefits are subject to the coordination of benefits provisions as stated in this booklet under Article XVIII titled, "Coordination of Benefits."

ARTICLE XV: VISION CARE BENEFIT

(For Active Participants and/or Dependents and Early Retirees and/or Dependents. Medicare eligible Retirees and their Dependents are not eligible for Vision Benefits)

Section 1: Overview

Vision care benefits are provided through a Vision Plan, whose name and address are listed on the Quick Reference Chart in the front of this document. The Vision Plan uses a panel of participating ophthalmologists and optometrists to provide discounted services to persons covered under the vision care program. Selecting a participating ophthalmologist and optometrist from the panel of participating providers assures direct payment to the provider of vision services as well as assurance of the finest qualified professional vision services and materials at a uniform cost.

Vision Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA.

Individuals are permitted to opt out of vision plan coverage by contacting the Administrative Office.

To make an appointment for eye exams contact the Vision Plan directly. There is no need to call the Administrative Office in advance for a benefit form. The vision care provider will verify your eligibility directly with the Vision Plan.

To use vision care benefits

- Make an appointment with a Vision Plan provider by calling the toll free Member Services Support Line or go to their Internet web site. See the Quick Reference Chart at the front of this document for the phone number and website.
- Tell the vision provider you are a member of this Vision Plan when making the appointment.
- After making the appointment, the vision provider and the Vision Plan will handle the rest by verifying benefits and eligibility for your services.

Section 2: SCHEDULE OF VISION BENEFITS
This chart shows what the Vision Plan pays. See also the Vision Plan Exclusions in this Article.

Covered Vision Benefits	Explanations and Limitations	Vision Plan Pays	
		In Network Provider	Non-Network Provider
Vision Examination • Includes analysis of visual function, including prescription of glasses, where indicated.	• One vision exam payable every 12 months.	Covered in full.	Up to $36.
Frames for Eyeglasses	• One frame payable every 24 months.	Value Frames: 100% after a $20 copay for lenses & frames	Up to $31.
Lenses for Eyeglasses	• Lenses payable once each 12 months, if the prescription change indicates. • Standard lenses are covered meaning, CR-39 basic plastic or white (clear) glass lenses. • A single vision, bifocal, trifocal lens is covered once each Plan year.	Single Vision (Standard): 100% Lined Bifocals: 100% Lined Trifocals: 100%	Single Vision: up to $25. Lined Bifocals: up to $41. Lined Trifocals: up to $53. Lenticular: up to $100 If only one lens is needed, the allowance will be one-half the pair allowance.

Section 2: SCHEDULE OF VISION BENEFITS This chart shows what the Vision Plan pays. See also the Vision Plan Exclusions in this Article.			
Covered Vision Benefits	**Explanations and Limitations**	**Vision Plan Pays**	
		In Network Provider	**Non-Network Provider**
Contact Lenses Medically necessary contact lenses are to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative as determined by the Vision Plan.	• The participant is to pay the difference between the cost of contact lenses and the amount allowed under this Vision Plan. • You may use your annual contact lens allowance toward permanent and/or disposable lenses.	Cosmetic Lenses (not medically necessary): up to $90 allowance Contact Lenses (medically necessary): up to $300 with prior authorization	Cosmetic Lenses (not medically necessary): Covered up to $60 allowance Contact Lenses (medically necessary): Covered up to $60 allowance

Section 3: Lenses and Frames

Where a correction is prescribed by a Vision Plan provider, the Plan includes the necessary materials and professional services connected with the ordering, fitting and adjusting of such materials.

1. **Lenses:** The Vision Plan provider will order the proper lenses from an approved laboratory.
2. **Frames:** The Vision Plan provider will assist the covered person in the selection of standard type frames. The Plan does not contain a limit on the cost of standard type frames. The additional cost of any non-standard frames must be paid by the covered person.
3. **Contact lenses:** The full cost of medically necessary contact lenses up to $300 are allowed in either of these instances:
   a. following cataract surgery; or
   b. when visual acuity cannot be corrected to 20/70 in the better eye except by their use.

   In all cases when contact lenses are in lieu of spectacles, such as for cosmetic or convenience purposes, reimbursement will be $90.

Section 4: Vision Plan Exclusions: What Is Not Covered

The following are not covered under this Vision Plan benefit:

1. Professional services or materials connected with:
   a. orthoptics or vision training
   b. contact lenses (except as noted in the Schedule of Vision Benefits)
   c. subnormal vision aids; aniseikonia lenses
   d. non-prescription lenses or sunglasses
   e. coated lenses (UV treating, scratch guard, tuff coat)
   f. no line bifocals (blended type)
   g. two pairs of glasses in lieu of bifocals
   h. tinted lenses except Pink #1 and #2
   i. oversized lenses as defined by certified labs
   j. lens facet grinding, drill mounting or polishing edges
2. **Replacement or repair of lost or broken lenses or frames**, including contact lenses, except at the normal intervals when services are otherwise available.
3. **Medical or surgical treatment of eyes**. These benefits are included under other portions of the Medical Plan.

4. Any eye **examination required by an employer** as a condition of employment.
5. Services or materials provided as a result of any **worker's compensation** law, or similar legislation, obtained through or required by a government agency or program whether federal, state or any subdivision thereof.
6. Charges for **treatment in a United States government hospital** or elsewhere at federal government expense unless required by law.

Section 5: Filing a Vision Claim/Appealing a Denied Claim

In-Network Provider: When you use the services of an in-network vision provider, you should pay the provider only for those services not covered by the Vision Plan. The vision provider will typically send the remainder of their bill directly to the Vision Plan for reimbursement.

Non-Network Provider: If you use the services of a non-network vision provider, you will need to pay the provider for all services and then, at a later date, but within six (6) months of the date of service, submit the bill to the Vision Plan (whose name and address are listed on the Quick Reference Chart in the front of document). You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits. Vision claims submitted beyond six months of the date of service may not be considered for reimbursement.

Reimbursement for services provided by or obtained from a non-network vision provider will be the **lesser** of the actual amount charged or the Allowed Charges or the amount listed in the Schedule of Vision Benefits under the column titled "Non-Network Provider."

Your appeal of any denied vision claims should also be submitted to the Vision Plan. Forward vision claims and appeals to the vision provider referenced on the Quick Reference Chart at the front of the document. See also the Claim Filing and Appeals Article XVII of this document.

Section 6: Coordination of Benefits

Vision expense benefits are subject to the coordination of benefits provisions included in this booklet.

ARTICLE XVI: LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

(FOR ACTIVE PARTICIPANTS)

This section outlines the fully insured Life and Accidental Death and Dismemberment (AD&D) Insurance coverage; however, where this Article deviates from the certificate of coverage and summary of benefits produced by the Life insurance and AD&D insurance company, the insurance company documents will prevail. Contact the Life and Accidental Death & Dismemberment insurance company (whose name is listed on the Quick Reference Chart in the front of this document) for more information on the Life and AD&D insurance benefits.

Section 1: Overview

When the company providing the death benefit insurance (as noted on the Quick Reference Chart in the front of this document) receives proof of the death of an active participant while insured for this benefit, it will pay the amount of life insurance shown in the Schedule of Benefits (at the front of this document). Payment will be made under the terms of the beneficiary provisions.

Section 2: Optional Settlement

Upon request, all or part of the life insurance amount will be paid in equal monthly installments. The request must be made in writing by the covered person or, if deceased, by a beneficiary other than the estate. The terms of the settlement must agree with the insurer's practice at the time of the request.

Section 3: Amount of Insurance During the Extension Period

The amount of life insurance extended shall not exceed the amount in force just before the extension starts.

Section 4: Proof of Disability

Proof of total disability must be furnished by the covered participant when required by the insurer, though not more than once each year.

Section 5: Date Extension Ceases

The extension will cease on the date the eligible active participant ceases to be totally disabled. If proof of disability for which the insurer has made a request is not furnished, the total disability will be deemed to cease on the date of the request.

If eligible as a participant on the date the extension and premium payments are resumed and within 31 days after that date, the eligible active participant will be insured for the amount which then applies to the eligible active participant's insurance class. If the participant is not then eligible under the policy, life insurance shall cease. Application may then be made for a personal policy under the terms of the life insurance conversion, whether or not the group policy is then in force.

Section 6: Written Notice of Death

Payment for death during the extension will be made only if proof of death is sent to the insurer within 12 months from the date of death.

Section 7: Life Insurance Conversion

When life insurance terminates for a covered participant under the group policy because the covered participant ceases to be eligible, a personal policy of life insurance may be obtained without evidence of insurability, subject to the provisions below.

Section 8: Definition

Life conversion period is the 31-day period commencing on the date the life insurance under the group policy ceased.

Section 9: Death During Conversion Period

If the covered participant dies during the life conversion period, the amount of life insurance for which the covered participant was insured under the group policy shall be payable under the group policy. This is in lieu of payment under a personal policy, even though it had been delivered or applied for.

Section 10: The Personal Policy

If the life insurance coverage ends for your group for any reason after you have been insured under this Plan for at least three years, you may convert up to $12,000 of your life insurance to a personal policy. The personal policy will be issued without medical examination and will not become effective before the end of the 31-day conversion period.

If you are not given written notice of your conversion privilege at least 15 days before the end of the 31-day conversion period, it will be extended to the earlier of:

1. 25 days after the date notice is given; or
2. 91 days after your group term life insurance coverage ends. Written notice may be presented to you or mailed to your last known address.

Section 11: ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (For Active Participants)

If, while insured for this benefit, the covered participant suffers accidental bodily injury which, independent of all other causes, results in any of the losses described herein, the company will pay the benefits stated below. Payment for dismemberment will be made to the covered participant. Payment for loss of life will be made under the terms of the beneficiary provisions. The loss must occur within 90 days after the date of the accident causing the loss. If more than one loss is sustained as a result of the accident, payment shall be made for only the one loss for which the largest amount is payable. No loss sustained prior to such accident shall be included in determining the amount payable.

A. Accidental Death

For loss of life, the amount shown in the Schedule of Benefits is payable.

B. Dismemberment

For the losses described below:

1. The amount shown in the Schedule of Benefits is payable for the loss of both hands, both feet, one hand and one foot, one hand or the sight of one eye, one foot and the sight of one eye, or the sight of both eyes.
2. One-half the amount shown in the Schedule of Benefits is payable for the loss of: one hand, one foot or the sight of one eye.

C. Definitions

Loss of sight means total and permanent loss of sight. Loss of a hand means severance of the hand at or above the wrist. Loss of a foot means severance of the foot at or above the ankle.

D. Assignment

Accidental death and dismemberment benefits may not be assigned.

E. Exclusions

No benefit will be paid for any loss that is cause directly or indirectly, or in whole or in part, by any of the following:

1. mental, nervous or emotional disorder or disease of any kind;
2. ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
3. suicide or attempted suicide while sane or insane;

4. intentional self-inflicted injury;
5. participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion;
6. war or act of war, declared or undeclared; or any act related to war, or insurrection;
7. medical or surgical treatment of an illness or disease; or
8. travel or flight as pilot or crew member in any kind of aircraft.

F. Beneficiary Provisions Applicable To Loss Of Life

- **For Active Participant**

  Named beneficiary means the party or parties which are designated to receive the benefits which are payable on account of death.

- **Payment to Beneficiary**

  Benefits for loss of life are payable to the named beneficiary if such party survives the eligible active participant. If there is no named beneficiary or if the named beneficiary does not survive the eligible active participant, the benefits are payable to the surviving person or persons in the first of the following classes of successive preference: spouse, children (including legally adopted children), parents, brothers and sisters, executor or administrator. The insurer may rely on an affidavit by a person in any of the classes of preference beneficiaries as the basis for the insurer's payment. Payment made before the insurer has received written notice at the company's home office of a valid claim by some other person releases the insurer from further obligation.

  The named beneficiary, if any, will be the person or persons named by the eligible active participant in the most recent written beneficiary designation placed on file in the records of the Trust Fund. Payment made by the company to such named beneficiary releases the insurer and the Trust Fund from further obligation.

  If two or more persons become entitled to benefits as the named beneficiary and the eligible active participant has not specified their respective interests, or as preference beneficiaries, they will share equally.

G. Assignment

Life insurance benefits may not be assigned by a beneficiary.

ARTICLE XVII: CLAIMS FILING AND APPEAL INFORMATION

Section 1: Overview

This Article pertains to claims administration for benefits under the Medical Plan (including the Prescription Drug benefits and the Hearing Aid benefit), Indemnity Dental Plan, the Vision Plan and the Weekly Disability Benefit provisions of this Plan. The Plan takes steps to assure that **plan provisions are applied consistently** with respect to you and other similarly situated plan participants. The claims process outlined in this Article are designed to **afford you a full, fair and fast review of your claim**.

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

Section 2: Qualified Medical Child Support Orders (QMCSOs)

This Plan will provide benefits in accordance with a **National Medical Support Notice**. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan determines that it has received an QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO.

For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Administrative Office.

Section 3: When You Must Repay Plan Benefits

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

- some or all of the health care expenses were not paid or payable by you or your covered Dependent; or
- you or your covered Dependent received money to pay some or all of those expenses from a source other than the Plan; or
- you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the expenses for which Plan benefits were paid; or
- the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan, or
- the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;
- then, the Plan will be entitled to
    a. recover overpayments from the entity to which the overpayment was made, or on whose behalf it was made; or from the participant directly;
    b. a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;
    c. offset future benefits if necessary in order to recover such expenses;
    d. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

Section 4: TIME LIMIT FOR FILING HEALTH AND DISABILITY CLAIMS

All post-service claims must be submitted to the plan within **15 months** from the date of service. All disability claims must be submitted to the plan within **90 days** from the date of onset of the disability.

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

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

Section 5: Coordination Of Benefits (COB) Provision

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

Section 6: Additional Information Needed

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

Section 7: When You Must Get Plan Approval in Advance of Obtaining Health Care

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this Article. You are not required to obtain approval in advance for emergency care (including care provided in a hospital Emergency room) or hospital admission for delivery of a child. Precertification is explained in Article II.

Section 8: Key Definitions (displayed alphabetically)

a. **Adverse Benefit Determination**: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as:
   - a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
   - a reduction in a benefit resulting from the application of any utilization review decision, pre-existing condition exclusion (if applicable), source of injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
   - a rescission of coverage, including disability coverage, whether or not there is an adverse effect on any particular benefit at that time.

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

Appropriate Claims Administrator	Types of Claims Processed
Administrative Office	• Medical post-service claims. • Disability claims.
Medical Review Company	• Urgent, Concurrent and Preservice claims.
Prepaid Dental Plan Claims	• Pre-paid Dental post-service claims.

Appropriate Claims Administrator	Types of Claims Processed
Administrator	
Indemnity Dental Plan Claims Administrator	• Indemnity Dental post-service claims.
Prescription Drug Program Claims Administrator	• Post-service claims for non- network retail drugs.
Vision Plan Claims Administrator	• Preservice (also called precertification review) of certain vision services/supplies as noted in Article XV. • Post-service vision claims.
Life Insurance and Accidental Death and Dismemberment Claims Administrator	• Life Insurance Post-service Claims. • Accidental Death and Dismemberment Post-service Claims.

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

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

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

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

A claim is NOT:

- a request made by **someone other than** the individual or his/her authorized representative;
- a request made by a **person who will not identify him/herself** (anonymous);
- a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
- an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim.
- a **submission of a prescription** with a subsequent adverse benefit determination at the point of sale at a retail pharmacy or from a mail order service.
- a request for an eye exam, lenses, frames or contact lenses with a subsequent adverse benefit determination at the point of sale from the Plan's contracted in-network PPO vision providers.

d. **Concurrent Care Claim:** A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

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

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

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

h. **Independent Review Organization or IRO:** Means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan's external review provisions and current federal external review regulations.

i. **Life Insurance/Accidental Death and Dismemberment Insurance Claim:** A life insurance/AD&D claim is a claim for benefits under the Plan to which the Plan conditions availability of the benefit on proof of a claimant's death or proof of accidental dismemberment.

j. **Post-Service Claim:** A post–service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

k. **Pre-Service Claim:** A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require precertification are listed in the Medical Review Article II and Vision Plan Article XV of this document.

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

l. **Rescission:** Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions.

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

n. **Urgent Care Claim**: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification, as determined by your Health Care Professional:
   - could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function, or
   - in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

Section 9: Review of Issues That Are Not a Claim as Defined in This Article

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

Section 10: Authorized Representative

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination

under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a network Health Care Professional.

The Plan requires a written statement from an individual that he/she has designated an authorized representative along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form (available from the Appropriate Claims Administrator).

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

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator.

In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

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

Section 11: Complying With Mental Health Parity And Addiction Equity Act (MHPAEA)

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

Section 12: How to File a Claim for Disability Benefits (Disability Claim Process)

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

In the case of disability benefit claim determinations and claim appeals, the plan will take steps to ensure that claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits. Medical and vocational experts will be selected based on their professional qualifications.

The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Eligible employees who become totally disabled from a non-occupational illness should apply (file a claim) for disability benefits within 30 calendar days (but no later than 90 days) after the date of onset of the disability, according to the following steps:

1. Obtain a disability claim form from the Appropriate Claims Administrator. Complete the patient portion of the form. Then give the form to your physician to complete the health care provider section of the form. Return the completed disability claim form (including proof of the disability) to the Appropriate Claims Administrator at their address listed on the Quick Reference Chart in the front of this document. **Disability claims will be determined not later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.**
2. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information.
3. Proof of disability must be provided to the Plan no later than 90 calendar days after the date of onset of the disability. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.
4. The Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.
5. The Board of Trustees or its designee determines if employees are eligible to receive disability benefits under this Plan. The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) not later than 45 calendar days from the date the Appropriate Claims Administrator receives the claim.
6. This 45-day period may be **extended for up to 30 calendar days** provided the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.
7. If, prior to the end of this first 30 day extension, the Appropriate Claims Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.
8. A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. **If the Appropriate Claims Administrator needs additional information from you to make its decision**, you will have at least 45 calendar days to submit the additional information. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
9. Disability benefits begin when the claim for disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim.
10. **If the claim for disability benefits is approved**, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.
11. **If the claim for disability benefits is denied** in whole or in part, a notice of this initial denial (adverse benefit determination) will be provided to the employee in writing (or electronically, as applicable). This notice of initial denial will:

a. give the specific reason(s) for the denial of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the plan);
b. reference the specific Plan provision(s) on which the determination is based;
c. contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;
d. describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
e. provide an explanation of the Plan's appeal procedure along with time limits;
f. contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal; and
g. describe any applicable contractual limitation periods on benefit disputes (such as the Plan's time limit on when a lawsuit may be filed following an appeal);
h. if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
i. if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

12. If you do not understand English and have questions disability benefits, filing a claim for disability benefits or about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.

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

Section 13: Appeal of a Denial of a Disability Claim

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

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit to written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

  Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of

Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
  a. consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  b. provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. A determination on the appeal will be made not later than **45 calendar days** from receipt of the appeal.
2. T**he Plan may obtain a 45-day extension if** you are notified of the need and reason for an extension before expiration of the initial 45-day period. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
3. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the plan);
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA section 502(a) following the appeal;
   - describe any applicable contractual limitation periods on benefit disputes (such as the Plan's time limit on when a lawsuit may be filed following an appeal);
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
4. If you do not understand English and have questions disability benefits, filing a claim for disability benefits or about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.

- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.

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

Section 14: How To File a Post-Service Claim for Benefits Under This Plan

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

1. Plan benefits for post-service claims are considered for payment on the receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim, but sometimes additional information or records may be required.

2. Generally, Plan benefits for a Hospital or Health Care Facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services.

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

4. If you pay for non-PPO health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered dependent paid some or all of those charges. Plan benefits will be paid to you up to the amount allowed by the Plan for those eligible expenses. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.

5. **Claim Forms:** Occasionally a health care provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this Article) to find out if they require you to complete a claim form. If a claim form is required it may be obtained from the Appropriate Claims Administrator whose name and address are listed on the Quick Reference Chart in the front of this document.
   - Complete the employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
   - The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician, Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
     - A description of the services or supplies provided.
     - Details of the charges for those services or supplies including CPT/CDT codes.
     - Diagnosis including ICD codes.
     - Date(s) the services or supplies were provided.
     - Patient's name, (social security or ID number), address and date of birth.
     - Insured's name, social security or ID number, address and date of birth, if different from the patient.
     - Provider's name, address, phone number, professional degree or license, and federal tax identification number.
   - Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.
   - Complete a **separate claim form** for each person for whom Plan benefits are being requested.
   - If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.
   - Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.

6. In all instances, when deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.
7. The Appropriate Claims Administrator will review your post-service claim not later than 30 calendar days from the date it receives the claim. You will be notified if you did not properly follow the post-service claims process.
8. This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30-day period using a written Notice of Extension.
9. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
10. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
11. The Appropriate Claims Administrator will then make a claim determination not later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.
12. **Proof of Dependent Status:**
    - When processing claims submitted on behalf of a **newborn Dependent** Child the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (*e.g.* copy of certified birth certificate for newborn).
    - When processing claims submitted on behalf of **certain categories of Dependent Children age 26 and older** the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g. full time student status verification for children under a legal guardianship, verification of disability).
    - When processing claims submitted on behalf of a **new spouse**, the Appropriate Claims Administrator must receive confirmation of the spouse's eligibility (e.g. copy of marriage certificate).
    - When processing **claims related to an accident** the Appropriate Claims Administrator may need information about the details of the accident.
13. The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

    Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

    If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.
14. **If the post-service claim is approved,** you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

15. **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) in addition to the Explanation of Benefits or EOB form. This notice of initial denial will:
    - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
    - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or external review;
    - give the specific reason(s) for the denial including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
    - reference the specific Plan provision(s) on which the determination is based;
    - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
    - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    - provide an explanation of the Plan's internal appeal procedure and external review processes (when external review is relevant) along with time limits and information regarding how to initiate an appeal;
    - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed; and
    - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
    - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
    - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals.
16. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.
17. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 15: Appeal of a Denial of a Post-Service Claim

This Plan maintains a 1 level appeals process. Appeals must be in writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

  Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The

rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

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

1. The Plan will make an appeal determination according to the following timeframes:
   - **If an appeal is filed with the Plan <u>more than 30 days</u> before the next Board meeting**, the review will occur at the next Board meeting date.
   - **If an appeal is filed with the Plan <u>within 30 days</u> of the next Board**, the Board review will occur no later than the second meeting following receipt of the appeal.
   - If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
   - After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.
2. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not a subordinate to the person who originally denied the claim.
3. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
4. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;

- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- an explanation of the Plan's appeal procedure and the external review process (when external review is relevant), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals.

5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.

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

Section 16: How to File an Urgent Care Claim for Benefits under this Plan

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

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

2. In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.

3. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

   Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

   If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

4. You will be notified of the Plan's benefit determination as soon as possible but **not later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.

5. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but not later than 24 hours after receipt of the urgent care claim by the Appropriate Claims Administrator, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but not later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

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

7. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided not later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
   - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or external review;
   - give the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process for urgent care claims;
   - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
   - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals processes.

8. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.

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

Section 17: Appeal of a Denial of an Urgent Care Claim

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

1. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - automatically, and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

     Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

     If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the Plan will:
     - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

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

3. The notice of appeal review of an urgent care claim will be provided orally with written (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided.
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;

- reference the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- an explanation of the Plan's appeal procedure and the external review process (when external review is relevant), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals processes.

4. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.
5. This concludes the urgent care claim appeal process under this Plan. This Plan does not offer a voluntary appeals process.

Section 18: How to File a Concurrent Claim for Benefits under this Plan

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

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.
2. The Plan will provide you automatically, and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

   Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

   If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.
3. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this Article.

4. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Preservice or Post-service claim sections of this Article.

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

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

6. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.

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

Section 19: Appeal of a Denial of a Concurrent Care Claim

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

1. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

  Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

  If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

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

3. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - an explanation of the Plan's appeal procedure and the external review process (when external review is relevant), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

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

4. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.
5. This concludes the concurrent claim appeal process under this Plan. This Plan does not offer a voluntary appeal process.

Section 20: How to File a Pre-Service Claim for Benefits under this Plan

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

1. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Medical Review Article II and Vision Plan Article XV of this document) to the Appropriate Claims Administrator (as defined in this Article).
2. The pre-service claim will be reviewed not later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you did not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
3. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15 day period using a written Notice of Extension.
4. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
5. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
6. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
7. A claim determination will be made not later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will make if no additional information is received.
8. The Plan will provide you automatically, and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

   Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

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

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

11. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.

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

Section 21: Appeal of a Denial of a Pre-service Claim

This Plan maintains a 1 level appeals process. Appeals must be in writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:

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

evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

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

2. Under this Plan's 1 level appeal process, the Plan will make a determination on the appeal not later than 30 calendar days from receipt of the appeal. There is **no extension permitted** to the Plan in the appeal review process.

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

4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.

5. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

6. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal review or external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
   - a statement that you have the right to bring civil action under ERISA section 502(a) following the appeal;

- an explanation of the Plan's internal appeal procedures and the external review process (when external review is relevant), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.
8. This concludes the pre-service appeal process under this Plan. This Plan does not offer a voluntary appeal process.

Section 22: How To File a Life and AD&D Claim for Benefits Under This Plan

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

1. Plan benefits for Life and AD&D claims are considered for payment on the receipt of a **written** (or electronic where appropriate) proof of claim. A completed claim usually contains the necessary proof of claim, but sometimes additional information or records may be required. Mail the claim form to the Appropriate Claims Administrator.
2. The Appropriate Claims Administrator will review your Life and AD&D claim not later than 30 calendar days from the date it receives the claim. You will be notified if you did not properly follow the Life and AD&D claims process.
3. This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30-day period using a written Notice of Extension.
4. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
5. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
6. The Appropriate Claims Administrator will then make a claim determination not later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.

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

8. **If the Life and AD&D claim is approved,** you will be notified in writing (or electronically, as applicable).

9. **If the Life and AD&D claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable). This notice of initial denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed; and
   - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

10. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.

11. **If you disagree with a denial of a Life and AD&D claim**, you or your authorized representative may ask for a Life and AD&D appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section 23: Appeal of a Denial of a Life and AD&D Claim

This Plan maintains a 1 level appeals process. Appeals must be in writing to the Life and AD&D Insurance company whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The

rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Life and AD&D Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. The Life and AD&D Insurance company will make an appeal determination within 60 days of receipt of the request for appeal.
2. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
3. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual will be requested to review the claim.
4. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 602-650-8161 or 800-669-1909.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 602-650-8161 or 800-669-1909.
6. This concludes the Life and AD&D claim appeal process under this Plan. This Plan does not offer a voluntary appeal process.

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

Section 24: Overview of Claims and Appeals Timeframes					
	Urgent	**Concurrent**	**Pre-service**	**Post-service and Life and AD&D**	**Disability**
Plan must make **Initial Claim Benefit Determination** as soon as possible but not later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days	45 days
Extension permitted during initial benefit determination?	No[1]	No	Yes, one 15-day extension.	Yes, one 15-day extension.	Yes, up to 2 extensions each 30 days in duration.
Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but not later than:	72 hours	Before the benefit is reduced or treatment terminated.	30 days	Post-service: Within the timeframe for Board meetings described below. Life and AD&D: 60 days	Within the timeframe for Board meetings described below.
Extension permitted during appeal review?	No	No	No	No	Yes

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

Section 25: Post-service and Disability Appeal Timeframes for a Multiemployer Plan with a Committee or Board of Trustees that meet at least Quarterly		
Appeal filed **within 30 days** of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal.	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Appeal filed **more than 30 days** before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.
Board's decision on the appeal to be provided to claimant as soon as possible after the Board decision but not later than 5 days after the Board's decision date.		

Section 26: External Review Of Claims

1. This voluntary External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

2. **External Review is only applicable in certain cases**. You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim,

whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within the following parameters:

(a) The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational, or medical judgment for determinations of whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act of 2008. The IRO will determine whether a denial involves a medical judgment; and/or

(b) The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

3. **External review is not available for** any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this **external review process does not pertain** to claims for life/death benefits, AD&D, disability, or the limited scope dental plan and vision plan.

   There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

4. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

5. There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

6. **External Review of Standard (Non-Urgent) Claims**.

   (a) Your request for external review of a standard (not urgent) claim must be made, in writing, **within four (4) months of the date that you receive notice** of an Initial Claim Appeal Benefit Determination (first level of appeal) or when applicable, an adverse Claim Appeal Benefit Determination (second level of appeal). For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

   (b) An external review request on a standard claim should be made to the following appropriate **Plan designee**:

      1) The Medical Plan Claims Administrator, with respect to a denied medical plan claim not involving retail or mail order prescription drug expenses;

      2) The Prescription Drug Program provider, with respect to a denied claim involving outpatient retail or mail order prescription drug expenses;

      3) The Medical Review Program provider, with respect to a denied Pre-service or concurrent review determination not involving prescription drug expenses or behavioral health expenses.

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

   (c) **Preliminary Review of Standard Claims**.

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

         i. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

ii. The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;

iii. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

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

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

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

ii. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

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

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

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

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

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

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

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

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information,

including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

v. The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee **within 45 days** after the IRO receives the request for the external review.

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

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

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

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

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

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

d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

e) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

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

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

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

(a) You may request an expedited external review if:

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

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

(b) Your request for an expedited external review of a non-standard claim should be made to the following appropriate **Plan designee**:

1) The Medical Review Program provider, with respect to a denied Urgent, Pre-service or Concurrent review determination not involving outpatient retail or mail order prescription drug expenses;

2) The Prescription Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;

Contact information for the Medical Review Program provider, and the Prescription Drug Program provider is identified in the Quick Reference Chart, as amended from time to time.

(c) **Preliminary Review for an Expedited Claim**.

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

(d) **Review of Expedited Claim by an Independent Review Organization (IRO)**.

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

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

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

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

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

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

Section 27. Overview of the Timeframes During the Federal External Review Process.

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan or appropriate Plan designee performs preliminary review	Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request	Immediately
Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review	Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review	Immediately
When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan or appropriate Plan designee assigns case to IRO	**In a timely manner**	**Expeditiously**
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan or appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses it's denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

Section 28: Discretionary Authority of Plan Administrator and Designees

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

Section 29: Facility Of Payment

If the Plan determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support.

Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Board of Trustees, Appropriate Claims Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Section 30: Limitation On When A Lawsuit May Be Started

You or any other claimant may not start a lawsuit to obtain benefits until after you have exhausted this Plan's Claims procedures or until the appropriate time frame described above has elapsed since you filed a request for review. You may not take legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review, or if you have not received a final decision or notice that an extension (an additional 60 days) will be necessary to reach a final decision. No lawsuit may be started more than 3 years after the date of the last denial of your claim, or, if the claim is for short term disability benefits, more than 3 years after the start of the disability.

Section 31: Elimination Of Conflict Of Interest

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

ARTICLE XVIII: COORDINATION OF BENEFITS (COB)

The payment of a benefit under the Plan is subject to coordination of benefits (COB).

Section 1: How Duplicate Coverage Occurs

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

- Another group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA Continuation Coverage); or
- Medicare; or
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle insurance including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
- Workers' compensation.

Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

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

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in Article XIX, General Information). Duplicate recovery of health care expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

Section 2: Definitions

- **Coordination of benefits** means that if the eligible person is entitled to medical benefits or services under more than one plan, the total amount payable under this Plan, when added to the amount or value of the benefits or services provided by all other plans, will not exceed the amount of the allowed expense which is incurred. In no event will the amount payable be more than would be payable if there were no other plan.
- **Plan** means any coverage for medical or dental care or treatment under an insurance policy, Medicare or other program of a government or established by law, a service plan contract, a prepayment plan or other non-insured plan. However, "plan" will **not** include:
  1. an accidental injury policy provided through a school or other educational institution;
  2. a hospital indemnity plan except as allowed by law;
  3. an individual policy except one which provides "no-fault" automobile insurance or is issued on a franchise basis; nor
  4. a state plan under Medicaid.
- **No-fault automobile insurance** means coverage under which personal injury benefits are paid as expenses accrue, without regard to fault. "This Plan" means the benefits provided by the Trust Fund.

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

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

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

Section 3: Coverage Under More Than One Group Health Plan

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits Article XVIII, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Covered Participant or that provides health care services to the Covered Participant. A "group plan" provides its benefits or services to participants, retirees or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Covered Individual with COBRA Continuation Coverage).
2. Many families have family members covered by more than one medical or dental plan. If this is the case with your family, **you must let this Plan and the Administrative Office know about <u>all</u> medical and dental plan coverages when you submit a claim.**
3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Section 4: Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

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

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

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

Rule 1: Non-Dependent or Dependent

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

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

Rule 2: Dependent Child Covered Under More Than One Plan

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

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

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

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

   If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose Birthday falls later in the calendar year pays second.

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

Rule 3: Active/Laid-Off or Retired Employee

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

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

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

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or

subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

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

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

Rule 5: Longer/Shorter Length of Coverage

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

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

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

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

Rule 6: When No Rule Determines the Primary Plan

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

Section 5: How Much This Plan Pays When It Is Secondary

For non-Medicare eligible Participants: When this Plan pays second, it will pay, 100% of "Allowable Expenses" **less** whatever payments were actually made by the plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans during a claim determination period is not more than 100% of total allowable expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first.

Section 6: Administration of COB

1. To administer COB, the Plan reserves the right to:
   - exchange information with other plans involved in paying claims;
   - require that you or your Health Care Provider furnish any necessary information;
   - reimburse any plan that made payments this Plan should have made; or
   - recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Administrative Office or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

4. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating

primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

5. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's Allowed charge.
6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
7. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Section 7: Exceptions for persons covered by Medicare: This Plan will pay its benefits before Medicare for:

a. an active participant;

b. a dependent spouse of an active participant; or

With regard to end-stage renal disease (ESRD), this Plan will be primary as required by the Medicare secondary payer rules in effect for this condition.

Section 8: What the Plan Pays when Medicare is the Primary Payer

If a covered person incurs expenses while covered under the Plan and is eligible for Medicare (whether or not covered by it); benefits otherwise payable under the Plan shall be reduced by Medicare benefits that were paid or would be payable for the expenses upon which a claim is based. In determining the Medicare benefits, the covered person is assumed to have full Medicare coverage including Parts A and B.

Coordination of Benefits with Medicare

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

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

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

c. **Coverage Under Medicare and This Plan When Totally Disabled:** If an eligible active employee or their dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible person will no longer be considered to remain actively employed. As a result, once the active employee or their dependent becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more employees.

d. **Coverage Under Medicare and This Plan for End-Stage Renal Disease:** If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

e. **Summary Chart on COB with Medicare:** If you are covered by Medicare and also have other group health plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	Situation	Pays First	Pays Second
Are covered by both Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage such as a group health plan has paid
Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working Spouse of any age	The employer has less than 20 employees*	Medicare	Group health plan
	The employer has 20 or more employees	Group health plan	Medicare
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Group health plan (*e.g.* a retiree plan coverage)
Are disabled and covered by a large group health plan from your work or from a family member who is working	The employer has less than 100 employees**	Medicare	Group health plan
	You are entitled to Medicare or the Employer has 100 or more employees	Group health plan	Medicare
Have End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Are covered under workers' compensation because of a job-related injury or illness	Entitled to Medicare	Workers' compensation for worker's compensation-related claims	Usually does not apply however Medicare may make a conditional payment.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	Federal Black Lung Benefits Program for black lung-related claims	Medicare
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for the accident-related claims	Medicare

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	Situation	Pays First	Pays Second
Are a veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service.	Usually does not apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider.	TRICARE may pay second
Are age 65 or over OR, are disabled and covered by both Medicare and COBRA	Entitled to Medicare	Medicare	COBRA
Have End-Stage Renal Disease (ESRD) and COBRA	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA
• *or if it is part of a multiemployer plan where one employer has 20 or more employees, if the Plan has requested an exception that is approved by Medicare. • ** and isn't part of a multiemployer plan where any employer has 100 or more employees. See also : https://www.medicare.gov/Pubs/pdf/02179.pdf or 1-800-Medicare for more information.			

Section 9: How Much This Plan Pays When It Is Secondary to Medicare

a. **When Covered by this Plan and also by Medicare Parts A and B:** When an eligible individual under this Plan is also covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the same benefits provided for active employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.

IMPORTANT NOTE FOR MEDICARE-ELIGIBLE RETIREES AND THEIR MEDICARE-ELIGIBLE DEPENDENTS

Benefits that are paid for by this Plan for Medicare-eligible Retirees and their Medicare-eligible dependents are reduced by the amounts payable under Medicare Parts A (Hospital), and B (Professional services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and B; therefore, if you are Medicare-eligible you should consider enrolling in Medicare Part A and B in order to receive the maximum amount of benefits under this Plan.

b. **When Covered by this Plan and Eligible for but Not Covered by Medicare:** When the Covered individual is covered by this Plan and is also **eligible for, but is not enrolled in Medicare Parts A, B and/or D**, this Plan pays the same benefits provided for active employees less the amounts that would have been paid by Medicare had the individual been covered by Medicare Parts A, B and D and not on the billed charges of the Health Care Provider.

c. **When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare beneficiary (meaning an individual who is determined by the Social Security Administration to be eligible for and has actually enrolled in Medicare benefits) is entitled to enter into a

Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare beneficiary enters into such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

d. **When Covered by this Plan and also by a Medicare Part D Prescription Drug Plan:** If you have dual coverage under both this Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage.

- For Medicare eligible Active Employees and non-Medicare eligible Retirees and individuals no longer actively employed but still receiving benefits based on hours accumulated when they were working and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.
- For Medicare-eligible Retirees and Medicare-eligible Dependents of Medicare-eligible Retirees, Medicare Part D coverage is your primary outpatient drug coverage because the Medicare-eligible Retiree Carve-Out Medical Plan does not provide outpatient drug coverage (you must elect the insured Medicare Part D prescription drug plan (PDP) if enrolled in this Plan's Medicare-eligible Retiree Carve-Out Medical Plan.
- For more information on Medicare Part D refer to www.medicare.gov or contact the Administrative Office.

Section 10: Coordination With Other Government Programs

a. **Medicaid**: If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

b. **TRICARE**: If a Covered Dependent is covered by both this Plan and the TRICARE Program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

c. **Veterans Affairs/Military Medical Facility Services**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are Allowed Charges.

d. **Motor Vehicle Coverage Required by Law**: If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second.

e. If an eligible individual under this Plan is covered for loss of earnings by both this Plan and any motor vehicle coverage that is required by law, including no-fault, uninsured motorist or underinsured motorist, the benefits payable by this Plan on **account of disability** will be reduced by the benefits available to you for loss of earnings pursuant to the motor vehicle coverage.

f. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

g. **Other Coverage Provided by State or Federal Law**: If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

h. **Workers' Compensation**: This Plan **does not provide benefits** if the expenses are covered by workers' compensation or occupational disease law. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. Before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Plan Administrator, (the Board of Trustees) or the Claims Administrator(s) of their rights to recover any payments that the Plan has advanced.

ARTICLE XIX: GENERAL INFORMATION

Section 1:

The Plan does not replace nor affect any requirement for coverage by worker's compensation insurance.

The effective time for any dates used herein shall be 12:01 a.m. standard time at the address of the Fund.

The Plan and the applications, if any, of covered persons constitute the entire contract. The Plan can be changed only by an endorsement issued by the Insurer and/or Fund.

The Fund will not use any statements, other than a fraudulent representation, by a covered person to contest a claim after his coverage has been in effect continuously for two years during his lifetime. If a claim is contested, a copy of such statement will be furnished to the covered person or his beneficiary.

Section 2: Examination and Autopsy

The Fund, at its own expense, has the right to have:

1. the covered person whose claim is pending, examined by a doctor of its choice. This right may be used as often as reasonably required.
2. an autopsy performed, if it is not prohibited by law. This applies to all coverages.

Section 3: Payment of Benefits

All benefits that are payable under this Plan, will be paid as soon as the Administrative Office receives satisfactory proof of the claim. No benefit will be paid for any charge, or portion of a charge that is: discounted, waived, or rebated by a provider simply because the covered person has insurance. The Fund shall have the right to recover any excess benefits paid for charges that were discounted, waived, or relocated from the covered person or the provider.

Section 4: To Whom Benefits Are Payable

All benefits are payable to the eligible participant. However, the Administrative Office may pay all or part of the benefits to the institution or individual providing treatment. The eligible participant may, by written assignment, request that benefits be paid to a provider, or to themselves, but not later than at the time proof of claim is given to the Administrative Office.

If benefits are to be paid to a minor; or any other covered person who, in the Administrative Office's opinion is not able to give a valid receipt for any payment due him, the Administrative Office will make payment to the covered person's legal guardian. If no legal guardian has been appointed, the Administrative Office may, at its option, make payment to the individual or institution who appears to be entitled to the payment. Payment so made shall discharge all liability under the Plan with respect to the amount.

The Fund may pay benefits to the non-insuring or custodial parent; or health care provider for a child, for whom the eligible participant is under a court order or a qualified medical child support order (QMCSO) to provide health insurance, when the non-insuring or custodial parent has incurred expenses relating to the health care provided to such child.

All disability benefits are payable to the active participant. If any indemnity under the Plan is payable to an eligible participant's estate, or to him or a beneficiary while he or they are a minor or otherwise not competent to give a valid release, the insurance company may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or marriage to the eligible participant or the beneficiary who is deemed by the Fund to be equitably entitled to it. Any payment made in good faith under this provision will fully discharge the Fund to the extent of such payment.

Section 5:Non-Assignment

Coverage and your rights to receive any benefits under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered. A

direction to pay a provider is not an assignment of any right under this Plan or under ERISA is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

Section 6: Claim Denial and Appeal

See the separate Claims Filing and Appeals Information Article XVII of this document.

Section 7: HIPAA Privacy

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Operating Engineers Local 428 Health and Welfare Plan (including PPO Networks, Claims Administration and Prescription Benefits Management), (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

a. The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

b. **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you and is also available from the Administrative Office. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and its Board of Trustees, will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.**

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Board of Trustees for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

1. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

    A. **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

    B. **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

        1. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

        2. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health

benefit claims, billing, collection activities and related health care data processing, and claims auditing;

3. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including precertification, concurrent review and/or retrospective review.

C. **Health Care Operations** includes, but is not limited to:

1. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,

3. Underwriting,(the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,

4. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,

5. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

6. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

2. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from the Plan's Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

3. **The Plan will disclose PHI to the Board of Trustees only in accordance with the following provisions**. With respect to PHI, the Plan and its Board of Trustees agree to:

- Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
- Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules,
- Not use or disclose the information for employment-related actions and decisions,
- Not use or disclose the information in connection with any other benefit or employee benefit Plan, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices),
- 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,
- Make PHI available to the individual in accordance with the access requirements of HIPAA,

- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
- Make available the information required to provide an accounting of PHI disclosures,
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
- If feasible, return or destroy all PHI received from the Plan that the Trustees maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction if feasible.
- If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

4. **In order to ensure that PHI is maintained in** accordance with HIPAA, only the following employees or classes of employees or other persons may be given access to use and disclose PHI:

   a. The Plan's Privacy Officer,

   b. As designated by the Plan Administrator, the benefits personnel of the Administrative Office involved in the plan administration of the Medical and Dental plan.

   c. Business Associates under contract to the Plan including but not limited to the medical and dental claims administrator, preferred provider organization network, the retail and mail order prescription benefit plan administrator, the Plan's attorneys, accountants and consultants/actuaries.

   d. The Board of Trustees, to the extent PHI must be reviewed in connection with a claim appeal or for such other purposes as may be required by law or the Plan documents.

   The persons described in this section above may only have access to and use and disclose PHI for Plan administration functions. If these persons do not comply with this obligation, the Board of Trustees has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.

5. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Board of Trustees will:

   a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

   b. Ensure that the adequate separation discussed in #4 above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

   c. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

   d. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Section 9: Third Party Liability

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise, (See the exclusion regarding Expenses for which a Third Party is Responsible in the Exclusions section of Article XII), but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or a representative, guardian, conservator, or trustee of the Covered Individual, and/or Dependent(s) if and when there is any recovery from any third party.

The right of reimbursement will apply:

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
3. without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
4. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule).
5. even if the recovery was reduced due to the negligence of the covered Employee or covered dependent (sometimes referred to as "contributory negligence"), or any other common law defense.

B. Reimbursement and/or Subrogation Agreement

The covered Employee **and/or** any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights**.

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

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

D. Subrogation

1. By accepting an Advance, the covered Employee and/or covered Dependent's jointly agree that the Plan will be subrogated to the covered employee and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s),

but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.

2. Under its subrogation rights, the Plan may, at its discretion:
   - start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or
   - intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

E. Application to Any Fund

1. The Plan's right to reimbursement and subrogation shall apply to any fund, account or other asset created:
   a. pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Employee and/or Dependent(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
   b. as a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Dependent(s).

F. Lien and Segregation of Recovery

By accepting the Advance the covered Employee and/or covered Dependent agrees to the following:

1. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment, or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.
2. The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.
3. Should the covered Employee, covered Dependent, or those acting on their behalf, fail to maintain this segregated account, or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed. Such remedy shall be in addition to any other available remedies under the terms of the Health Plan and applicable law.

G. Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

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

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

Section 10: General Statement Of Nondiscrimination: (Discrimination Is Against The Law)

Operating Engineers Local No. 428 Health and Welfare Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Fund:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Fund's Civil Rights Coordinator.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator for Operating Engineers Local No. 428 Health and Welfare Trust Fund,
c/o Zenith American Solutions
Mailing Address: P. O. Box 16200 Phoenix, AZ 85011-6200
Phone: 602-650-8161 or 800-669-1909
Fax: 602-248-8301

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Fund's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

Free Language Assistance: The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of Arizona:

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 602-650-8161 or 800-669-1909.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 602-650-8161 or 800-669-1909.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 602-650-8161 or 800-669-1909.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 602-650-8161 or 800-669-1909.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	Message About Language Assistance
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 602-650-8161 or 800-669-1909.
Persian/Farsi	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-602-650-8161; 800-669-1909 تماس بگیرید.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 602-650-8161 or 800-669-1909.
Navajo	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 602-650-8161 or 800-669-1909.
Arabic	المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-669-1909 or 602-650-8161 (رقم والبكم: 1-800-669-1909 or 602-650-8161). ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات هاتف الصم
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 602-650-8161 or 800-669-1909 번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 602-650-8161 or 800-669-1909.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 602-650-8161 or 800-669-1909.
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 602-650-8161 or 800-669-1909.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。602-650-8161 or 800-669-1909まで、お電話にてご連絡ください。
Assyrian (Syriac)	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܫܬܟܚܝܢ ܠܘܟܘܢ ܬܫܡܫܝܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 602-650-8161 or 800-669-1909.

ARTICLE XX: ERISA DISCLOSURE AND STATEMENT OF RIGHTS

The following information concerning the group Health and Welfare Plan is being provided to you in accordance with government regulations:

Section 1: The name and type of Plan:

The Operating Engineers' Local No. 428 Health and Welfare Trust Fund Plan is administered by a joint Board of Trustees, consisting of three Union Representatives and three Employer Representatives. The Welfare Plan provides life insurance, accidental death and dismemberment, short-term disability benefits, dental benefits, vision benefits and comprehensive medical benefits.

Section 2: The name and address of the Plan Administrator/Plan Sponsor is:

Board of Trustees Operating Engineers' Local No. 428 Health and Welfare Trust Fund
2001 W. Camelback Rd. Suite 350
Phoenix, AZ 85015-7404

Mailing Address:
P. O. Box 16200
Phoenix, Arizona 85011-6200
Phone: 602-650-8161

Section 3: The names and business addresses of the Trustees are:

Union Trustees	Employer Trustees
Mike Lee Operating Engineers Local No. 428 6601 North Black Canyon Hwy. Phoenix, AZ 85015-1027	David Martin Arizona Chapter A.G.C. 1825 West Adams St. Phoenix, AZ 85007-2603
Chad Gray Operating Engineers Local No. 428 6601 North Black Canyon Hwy. Phoenix, AZ 85015-1027	Tom W. Royden Royden Construction Co. 19612 West Hilton Ave Phoenix, AZ 85326-9033
Jay L. Stevens Operating Engineers Local No. 428 6601 North Black Canyon Hwy. Phoenix, AZ 85015-1027	Steve Campbell Pulice Construction Co. 2033 West Mountain View Rd. Phoenix, AZ 85021-1922

Section 4: In addition to the Board of Trustees, the following individuals have been designated as agents for the service of legal process:

Keith F. Overholt Esq. Jennings, Strouss & Salmon, P.L.C. One East Washington St, Suite 1900 Phoenix, AZ 85004-2554	Gerald Barrett, Esq. Ward, Keenan & Barrett, P.C. 2141 East Camelback Road, Suite 100 Phoenix, Arizona 85016

Section 5: Type of Administration

The life insurance and accidental death and dismemberment insurance benefits, are insured by a Life Insurance company whose name and address are listed on the Quick Reference Chart in the front of this document. The prepaid Dental Plan is insured by a Dental Insurance Company whose name and address are listed on the Quick Reference Chart in the front of this document.

The medical plan (including prescription drug benefits and hearing aid benefits), indemnity dental plan, vision plan and weekly disability plan benefits are self-funded.

- The Trustees have contracted with a medical Preferred Provider Organization (PPO) to provide discounted health care services at participating hospitals and providers for medical plan benefits.
- The Trustees have contracted with a Prescription Drug Management firm to provide discounted retail and mail order prescription drugs at participating pharmacies.
- The Trustees have contracted with a Vision Plan in order to utilize discounts from their panel of participating ophthalmologists, optometrists and opticians.

The Medical Plan PPO network, Prescription Drug Management firm, Indemnity Dental Plan and the Vision Plan have their names and addresses listed on the Quick Reference Chart in the front of this document.

The Trustees have contracted an independent Claims Administrator to administer the medical plan, indemnity dental plan and weekly disability plan benefits. The Claims Administrator's name and address is listed on the Quick Reference Chart in the front of this document.

Section 6: The **Employee Identification Number (EIN)** assigned by Internal Revenue Service to the Board of Trustees is 86-6025730.

Section 7: The **Plan Number** assigned by the Board of Trustees is 501.

Section 8: For purposes of maintaining the **Fund's fiscal records**, the yearend date is September 30.

Section 9: Funding Medium

Benefits and premium payments are provided from the Fund's assets which are accumulated under the provisions of Collective Bargaining Agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

Section 10: Contribution Source

All contributions to the Plan are made by employers in accordance with Collective Bargaining Agreements between the Operating Engineers' Local Union No. 428 and employers in the industry.

- The Collective Bargaining Agreements require contributions to the Plan at a fixed rate per hour worked.
- The Administrative Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan with respect to participants working under Collective Bargaining Agreements.
- See the section in this Article titled "Plan Documents" if you wish to obtain additional information about Collective Bargaining Agreements.

Section 11: Eligibility

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described under the Eligibility Rules Article III.

Section 12: Statement of ERISA Rights

As a participant in the Operating Engineers' Local No. 428 Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

1. Examine, without charge, at the Plan Administrator's office reflected in the Quick Reference Chart at the front of this Plan Document, and at other specified locations such as union halls, a copy of the latest updated Summary Plan Description and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract or other instruments under which the Plan is established or operated. A copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
2. Obtain, upon written request to the Plan Administrator, copies of the latest updated summary plan description and the latest annual report, any terminal report, the bargaining agreement, trust agreement,

contract or other instruments under which the Plan is established or operated. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

1. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA Article V. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

1. In addition to creating right 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.
2. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

1. If your claim for welfare benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
3. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Plan's Claims Filing and Appeal information on the requirement to appeal a denied claim and exhaust the Plan's appeal process **before** filing a lawsuit.
4. 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.
5. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

1. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and

Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210.

2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

Section 13: Claims Procedures

The procedures to follow for filing a claim for benefits are outlined on the inside front cover of this booklet and described in more detail in the Article titled "Claims Filing and Appeals Information" that is also part of this document. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

Section 14: Notice of Denial, Review Procedures

See the separate Claims Filing and Appeals Information Article of this document for detailed information.

Section 15: Plan Documents and Reports

The following documents may be examined at the Administrative Office during regular business hours, Monday through Friday, except holidays:

a. Trust Agreement;

b. Collective Bargaining Agreement;

c. Plan Document, policies and all amendments;

d. Form 5500 or full Annual Report filed with the Internal Revenue Service and Department of Labor;

e. List of contributing employers.

Copies of the documents may also be obtained by writing for them and paying the reasonable cost of duplication. Before requesting copies, find out what the charges will be. Reports can be examined during business hours, at the Union Office. To make such arrangements, call or write the Administrator at the Fund Office. A summary of the annual reports which gives details of the financial information about the Fund's operations is furnished free of charge to all participants.

This booklet contains (in English) the Plan rights and benefits under the Plan. If there is difficulty in understanding any part of this booklet, contact the Administrative Office at their phone number and address listed on the Quick Reference Chart in the front of this document.

Section 16: Spanish Language Assistance

Si no entiende los beneficios del Plan, pongase en contacto con la Oficina de Administracion, al numero 602-650-8161.

Section 17: Allocation And Disposition Of Assets Upon Termination

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these Plan Rules.

In addition, the Trust may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.